

**THE POWER OF TRANSPARENCY: GIVING
CONSUMERS THE INFORMATION THEY NEED
TO MAKE SMART CHOICES IN THE HEALTH
INSURANCE MARKET**

HEARING

BEFORE THE

**COMMITTEE ON COMMERCE,
SCIENCE, AND TRANSPORTATION
UNITED STATES SENATE**

ONE HUNDRED THIRTEENTH CONGRESS

FIRST SESSION

FEBRUARY 27, 2013

Printed for the use of the Committee on Commerce, Science, and Transportation



U.S. GOVERNMENT PRINTING OFFICE

88-434 PDF

WASHINGTON : 2014

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512-1800; DC area (202) 512-1800
Fax: (202) 512-2104 Mail: Stop IDCC, Washington, DC 20402-0001

SENATE COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

ONE HUNDRED THIRTEENTH CONGRESS

FIRST SESSION

JOHN D. ROCKEFELLER IV, West Virginia, *Chairman*

BARBARA BOXER, California	JOHN THUNE, South Dakota, <i>Ranking</i>
BILL NELSON, Florida	ROGER F. WICKER, Mississippi
MARIA CANTWELL, Washington	ROY BLUNT, Missouri
FRANK R. LAUTENBERG, New Jersey	MARCO RUBIO, Florida
MARK PRYOR, Arkansas	KELLY AYOTTE, New Hampshire
CLAIRE McCASKILL, Missouri	DEAN HELLER, Nevada
AMY KLOBUCHAR, Minnesota	DAN COATS, Indiana
MARK WARNER, Virginia	TIM SCOTT, South Carolina
MARK BEGICH, Alaska	TED CRUZ, Texas
RICHARD BLUMENTHAL, Connecticut	DEB FISCHER, Nebraska
BRIAN SCHATZ, Hawaii	RON JOHNSON, Wisconsin
WILLIAM COWAN, Massachusetts	

ELLEN L. DONESKI, *Staff Director*

JAMES REID, *Deputy Staff Director*

JOHN WILLIAMS, *General Counsel*

DAVID SCHWIETERT, *Republican Staff Director*

NICK ROSSI, *Republican Deputy Staff Director*

REBECCA SEIDEL, *Republican General Counsel and Chief Investigator*

CONTENTS

Hearing held on February 27, 2013	Page 1
Statement of Senator Rockefeller	1
Statement of Senator Thune	3
Statement of Senator Nelson	5
Statement of Senator Pryor	33
Statement of Senator Cruz	35
Statement of Senator McCaskill	36
Statement of Senator Schatz	39

WITNESSES

Lynn Quincy, Senior Policy Analyst, Consumers Union	5
Prepared statement	7
Michael A. Livermore, Executive Director, Institute for Policy Integrity, New York University School of Law	12
Prepared statement	14
Margaret O’Kane, President, National Committee for Quality Assurance	18
Prepared statement	20
E. Neil Trautwein, Vice President and Employee Benefits Policy Counsel, National Retail Federation	25
Prepared statement	27

APPENDIX

Response to written question submitted to Lynn Quincy by:	
Hon. John D. Rockefeller IV	47
Hon. Amy Klobuchar	47
Response to written question submitted by Hon. Amy Klobuchar to Margaret E. O’Kane	48

THE POWER OF TRANSPARENCY: GIVING CONSUMERS THE INFORMATION THEY NEED TO MAKE SMART CHOICES IN THE HEALTH INSURANCE MARKET

WEDNESDAY, FEBRUARY 27, 2013

U.S. SENATE,
COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION,
Washington, DC.

The Committee met, pursuant to notice, at 2:30 p.m., in room SR-253, Russell Senate Office Building, Hon. John D. Rockefeller IV, Chairman of the Committee, presiding.

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, U.S. SENATOR FROM WEST VIRGINIA

The CHAIRMAN. The hearing will come to order. And we—please forgive us; we were having a little bit of fun up here. It doesn't happen much around here, you know? You've got to take advantage of it when you can do that.

Almost 4 years ago—that being 2009, I was good at math—this committee held a hearing on many challenges that consumers faced when trying to buy health insurance. And we spent a lot of time in this committee on the health insurance industry and healthcare. And at that hearing, we heard that shopping for health insurance was frustrating, confusing, and stressful. Consumers had no really easy way to find out what they were about to get. And then, one of the problems was that, under the old system, what the insurance company sent them was what they had to take before—well, they had to buy the insurance first, you see, and then they got the information about what they just bought. And that wasn't really smart.

So, consumers didn't have any easy way to learn, or compare, which is the main thing, different healthcare plans. And that's the whole point of this. I mean, we're heading into a new era, 2014 almost on us. They could get slick marketing material from the insurance companies, which would say all kinds of things, but they couldn't get straight answers about the services a health insurance plan did, or did not, which is just as important, cover.

When they asked for further information about health insurance plans, consumers usually got bulky disclosure documents. We—I was hoping we'd have a lot of bulky disclosure documents around here so everybody could look at them. We don't? I don't want it; I've already seen it. But, it's a trip. Some of these 100 page—consumers would get a—100 page explanations of what they had already paid for and, therefore, were going to have to have.

So, they couldn't compare. They got their materials, but they couldn't get straight answers. And when they asked for further information about health insurance plans, consumers usually got these bulky things. And something which makes a point with me, you know, there's a fine print which can actually drive you crazy. That's the fine print which the insurance companies used. I mean, you take your Magellan magnifying glass and put it right down there, and you can just barely catch the word. And there was no standard terminology in health insurance. For example, "copay," "hospitalizations"—well, we all know what that means. No, we don't. It varies, according to what the insurance plan might be. "Out-of-pocket limit," what does that mean? Well, it meant many different things. So, consumers were kind of in the dark, and that's exactly where the health insurance companies wanted to keep them. And I'm not trying to be cynical about this, but it was—we had a fellow, named Wendell Potter, who testified, sat right there, Mr. Livermore, and he said that they did this purposely; they purposefully made things small, hard to read, long, legalese, healthcarese, so that people would just get discouraged from plowing through, and, therefore, would just go ahead and buy the product.

Mr. Potter told us that the industry's goal was to make their disclosure materials so impenetrable and confusing that consumers would give up and throw them away.

Now, as long as consumers couldn't understand what the policies—how they work, they wouldn't understand the bad deal they might be getting. Maybe they weren't, but maybe they were. They couldn't know.

While the market we've heard about in 2009 was profitable for health insurance companies, it was a disaster for families. And that's all well documented, and we've done that.

Consumers assumed that, if they paid their health insurance premiums every month, they were protected. I would have assumed that. I would have assumed that. It's the way America works. Only too late would they discover that the fine print in their health insurance plans stuck them with thousands of dollars in unexpected medical bills. A complicated pregnancy, a cancer diagnosis, or even a broken limb, could push families well beyond their budgets. In fact, medical debt had become the leading cause of personal bankruptcy filings. We all know that. That's been the case for years.

So, after hearing too many of these stories, some of us got serious about bringing more transparency in the health insurance market. So, we created a clear labeling requirement in the Affordable Care Act, or the—you know, the—the Act, the healthcare act, Obamacare, whatever you want. So, we put that in there; they had to have clear labeling, just like when you look at how much caloric content, fat content, et cetera, you tend to get it on something that you buy. We required health insurance companies to clearly and accurately disclose to their customers that their—what their policies cost—that is now law—and what their services might cover. Instead of 20 or 40 or even 100 pages—and I have all three in my back of my book here—disclosure documents—the law required insurers to give consumers about a 4-page document, a Summary of Benefits and Coverage, SBC; and it had to be written in plain

English. And it is. And it had to be printed in font that customers, like me, could read, which was a strict requirement.

The law also called for the development of industrywide standard definitions, so consumers could clearly understand words like “copay” or “hospitalizations.” They—in other words, what was true for one plan had to be true for another plan. Then you just put that into law, and then you try to enforce it; and presumably you can, although everything takes time. With clearly presented plan features describing—using standard terms—consumers could finally make apples-to-apples comparison—and that was good—between the health insurance projects—products, and find the one that best met their health coverage needs.

To help consumers understand how the policies would work in a real-life situation, the law also required insurers to give example of how their plans would cover the expenses of major health events, such as having a baby or treating a chronic disease, like diabetes. And then breast cancer comes into our discussion today, because people can identify—and you can see it in some of these plans, when you get them—how much individual—for, say, breast cancer, or for diabetes 2—I mean, what, exactly, are you paying? What, exactly, are you paying? It’s listed, and added up.

So, after extensive discussion and consumer testing, insurance companies began issuing SBCs in the fall of 2012. While there may be room for improvement—and there is—these forms represent a major step forward. I’m actually very happy about this, because it helps consumers make informed judgments, which they need to do.

So, with this new transparency, health insurance companies have a new incentive, to compete on the value of their product—the value of their products—and on their—not on their ability to confuse people.

So, in closing, our witnesses today are going to tell us about how the SBC was developed and what they think of the SBC as a tool for creating transparency and improving consumers’ health plans, and also how they think it could get better. I’ve got a bunch of ideas on that; you probably have more. We need to—while we’re in the mood to get this SBC going, and while companies are adjusting to it, let’s make it as helpful as possible to the consumer.

My honorable Ranking Member.

**STATEMENT OF HON. JOHN THUNE,
U.S. SENATOR FROM SOUTH DAKOTA**

Senator THUNE. Thank you, Mr. Chairman, for holding this hearing.

I appreciate all the witnesses who are here today to provide testimony. Thank you for being here.

And, as the Chairman has mentioned, today’s hearing follows hearings this committee conducted in 2009 which explored the connection between how health insurance companies share information about the benefits and coverage of their plans and the ability of consumers to make informed choices in the marketplace.

Mr. Chairman, I applaud your dedication to these issues.

Anyone who has had to compare healthcare plans and make decisions for themselves or their families likely shares the goal of im-

proving the transparency and clarity of the plans' descriptions, particularly in the individual and small group markets.

We're here to examine how healthcare plans share information with consumers in the health insurance market, and what changes have been made since 2009 specifically with regard to the implementation of the Summary of Benefits and Coverage provision, or SBC, which was championed by the Chairman.

Since 2009, the health insurance landscape has changed dramatically. Some changes, like the requirement that health insurers provide standardized statements of benefits and coverage, we hope are for the better. It's no surprise that Americans appear to embrace the idea that health insurance companies should provide easy to understand plan summaries.

Polling by the Kaiser Family Foundation in 2011 showed that nearly 84 percent of respondents in its tracking poll held, "very favorable" or "somewhat favorable" views on this idea.

As we explore the SBC today, which has yet to be fully implemented, it's my hope that the Committee will find that actual users' experiences are likely to match consumers' high expectations.

Health insurance is complicated, given the many variables that influence the actuarial assessments upon which coverage and premiums are based. Provisions, such as the SBC, should help simplify the process, but, at the same time, they must be implemented in a way that provides an accurate picture of what consumers can truly expect. The goals of clarity and transparency are goals that we all share, but we should not underestimate the ability of the government to implement good ideas in ways that create additional confusion for consumers.

While some provisions in the healthcare law offer promise, I am concerned that they pale against the backdrop of unwelcome changes we have yet to fully realize. I'm especially concerned about how the multitude of regulations mandated by the Affordable Care Act will affect premiums. A recent study by Oliver Wyman found that the President's health law will greatly increase the cost of insurance for those in the individual market by an average of 10 to 20 percent.

Taken as a whole, the regulatory burden of the Affordable Care Act is crushing. Since its enactment, there have been more than 18,000 pages of regulations issued. The SBC provision is just one small part of this, and it's my hope the discussion today will provide an opportunity to explore ways in which we can increase its utility. But, as we seek to protect consumers, we cannot ignore the larger law's likely impact on premium increases. Perhaps our laws, like our health plans, should come with a straightforward summary of their likely cost and benefits to taxpayers; I think that would be refreshing, as well.

So, I want to thank you all for being here. I look forward to hearing your testimony and the opportunity to interact with you, in some questions, and get your perspective on the SBC.

Thank you, Mr. Chairman.

The CHAIRMAN. I want to thank my Honorable Ranking Member, and beg his indulgence, because I asked Senator Nelson if he wanted to speak, which he has absolutely no right to do, under our

rules, as well established, but he said he wanted to say 20 seconds of nice things about me.

[Laughter.]

The CHAIRMAN. So, I decided——

Senator THUNE. We'd better indulge that.

The CHAIRMAN. What I—that was my thinking.

[Laughter.]

The CHAIRMAN. The Senator from Florida.

**STATEMENT OF HON. BILL NELSON,
U.S. SENATOR FROM FLORIDA**

Senator NELSON. Mr. Chairman, Mr. Ranking Member, I did want to say some nice things about you, because it is the passion that you continue to carry, from being one of the coauthors of the Affordable Care Act, that you bring to the chairmanship of this committee in such things as the hearing today, how to make it better.

With your indulgence, I have the privilege of chairing my first hearing, in the Aging Committee, of which the subject matter is how to improve the healthcare bill that was passed back in 2009.

So, Mr. Chairman, I want to thank you for your continuing passion.

The CHAIRMAN. Senator Thune, he did overrun his time a bit.

[Laughter.]

The CHAIRMAN. But, I think that, in the spirit, we should be grateful.

Senator THUNE. That's right. Unanimous consent, Mr. Chairman, that he be allowed to use as much time as he already has used.

[Laughter.]

The CHAIRMAN. OK.

Now our panel: Ms. Lynn Quincy, who's the Senior Policy Analyst of the Consumers Union—and you're smiling, which is good, because you'll be first up; Mr. Michael Livermore, Executive Director, Institute for Policy Integrity, New York University School of Law; Ms. Margaret—a.k.a. Peggy—O'Kane, President, National Committee for Quality Assurance; and Mr. Neil Trautwein, who's Vice President, Employee Benefits Policy Counsel, of the National Retail Federation.

So, please give your testimony, and then we'll have questions for you.

**STATEMENT OF LYNN QUINCY, SENIOR POLICY ANALYST,
CONSUMERS UNION**

Ms. QUINCY. Senator Rockefeller, Senator Thune, and members of the Committee, thank you so much for having me here today. I'm absolutely delighted, on behalf of consumers everywhere, to come and talk about the Summary of Benefits and Coverage.

I think we can all agree, health insurance is necessary for the health and financial security of American families. What's more, consumers must be fully informed about how their health insurance works, as has already been referenced.

We do not want them out in the marketplace, shopping with a blindfold on. And I'm afraid that's a little bit too common, still. The Summary of Benefits and Coverage goes a long way toward taking

off the blindfold and helping them understand their coverage options.

Today, we're releasing a nationally representative survey that shows how the Summary of Benefits and Coverage fared in the marketplace last fall. This is our first experience with it out in the marketplace, and I'll share a few findings with you. We also have evidence from pretesting of the form that was done by Consumers Union and by health plans when it was being developed. And, taken together, we have a really rich body of evidence, which says how consumers respond to this form. And I'd love to share just a couple highlights, because they're all good.

These are just the very—there we go—it's a very visual form, so we've got to look at it while we're talking about it. Here are just a few highlights from all of this evidence. One, consumers love the fact that they can line up plans from different carriers or different employers and compare them, apples to apples. This is a big deal for them.

They are very reassured by the element that says why this matters, because they aren't sure why different features matter. They really need help understanding how these important cost-sharing features work, and whether or not it's important to pay attention to them.

They really like having exceptions to coverage all in one place. It helps alleviate some of the worry they feel about the fine print that Senator Rockefeller referred to.

They—but, what proved transformational, when we did our testing, is this element: the coverage example. The coverage example—in this case, it's a medical scenario of having a baby—tells consumers three things that they've never seen before.

One, how much does healthcare cost? Well, they don't know; and so, they don't know how much insurance they need. The coverage example takes care of that problem.

It shows a bottom line for how much they would pay. That's another thing they don't know, because consumers find it very, very difficult to roll up all those disparate cost-sharing provisions, like benefit limits and annual limits and out-of-pocket maximums. It's pretty high-level math.

And third, and perhaps most surprising, it shows what the plan pays. And here—this shows the real value of consumer testing. That may not seem important; it may seem like it's simply a residual. Well, it's not. It reminded them of the importance of insurance coverage and the fact that an unexpected medical event might happen to them, and that they, if they have coverage, even if it has what seemed like a high deductible, they're still getting a benefit, because they can see the number that represents what the health plan paid on their behalf. And perhaps you'll recall that traditional health plan materials don't actually include that information.

So, this was enormous. And it's a wonderful tool in your policymakers' toolbox that you can be exploiting as we go forward with the SBC.

I mentioned the survey in the fall. Here's the bad news. Only half of consumers, in the fall, who shopped for private health insurance coverage recalled seeing the SBC. We must do a much better

job of raising awareness. And I suspect we need to do a better job of getting the health plans to comply with the requirements.

The good news is, when they did see the Summary of Benefits and Coverage, the survey respondents told us that they viewed it very favorably, and they told us it was more helpful than any other form of health plan information that we gave them in a list. This is things like information you get from your employer, advice from a broker, et cetera. So, good news, except for the awareness factor.

Going forward, I hope that we will do things to improve the SBC, maybe get it professionally designed, add more coverage examples, and all the other recommendations I included in my written testimony.

I will stop there. Thank you so much.

[The prepared statement of Ms. Quincy follows:]

PREPARED STATEMENT OF LYNN QUINCY, SENIOR POLICY ANALYST,
CONSUMERS UNION

“A RETROSPECTIVE AND PROSPECTIVE LOOK AT THE SUMMARY OF BENEFITS AND
COVERAGE FORM”

Introduction

Consumers Union, the policy and advocacy arm of *Consumer Reports*,¹ appreciates this opportunity to provide testimony on the new health insurance disclosure—the *Summary of Benefits and Coverage* or SBC form.

The SBC provides a very important consumer protection. For the first time, consumers have a standardized disclosure that allows them to compare health plans, even plans from different carriers or different employers. This uniform, consumer-friendly information arms consumers to be better shoppers and, in turn, improves the insurance market place. What’s more, a robust body of evidence shows this product is working as intended.

My testimony describes this evidence and recommends some next steps for the SBC and for consumer disclosures more generally.

Brief Background

The SBC requirement was included in the 2010 Affordable Care Act, based on legislation introduced earlier by Senator Rockefeller (D-WV).² The statute described not only what should be in the SBC but also legislative goals for the document:

- [Standards] shall ensure that the summary is presented in a culturally and linguistically appropriate manner and *utilizes terminology understandable by the average plan enrollee*.
- Uniform definition of terms so that “*consumers may compare health insurance coverage and understand the terms of that coverage (or exception to such coverage)*”;

Health insurance is costly and has profound implications for the health and financial security of America’s families. Hopefully, all would agree it is important that consumers be armed with information that is understandable, reliable, allows them to divine how much coverage they are getting and can be readily compared across health plans. The SBC requirements were a major step forward in this regard.

We all know that not every consumer disclosure works in practice as intended by legislators. Consumers Union thinks it is very important to directly assess the impact of required disclosures on consumers. Two things must be done to reliably conduct this assessment: (1) use independent, trained moderators to test disclosures with real consumers simulating real marketplace conditions as closely as possible; and (2) monitor how well the disclosure functions in the marketplace after roll out.

¹ Consumer Reports is the world’s largest independent product-testing organization. Using its more than 50 labs, auto test center, and survey research center, the nonprofit rates thousands of products and services annually. Founded in 1936, Consumer Reports has over 8 million subscribers to its magazine, website, and other publications. Its advocacy division, Consumers Union, works for health reform, food and product safety, financial reform, and other consumer issues in Washington, D.C., the states, and in the marketplace.

² *Informed Consumer Choices in Health Care Act of 2009*.

As described below, for the SBC we have a robust body of evidence that shows this product is truly helping consumers and is as good or better than other information found in the market today.

Evidence from Testing

For four years, I have served as a consumer representative with the National Association of Insurance Commissioners (NAIC), the organization tasked with initial development of the SBC form. NAIC reached out to a diverse group of stakeholders to develop the form, but did not plan any consumer testing. Nor did any of the Federal agencies tasked with writing the regulations on the SBC plan to conduct consumer testing.

As a result, with the support of some generous foundations,³ Consumers Union stepped in to do two rounds of consumer testing on the prototype document.⁴ America's Health Insurance Plans and Blue Cross Blue Shield Association also tested the prototype document.⁵ This testing used either focus groups or cognitive interviews⁶ to learn how and when consumers would use the prototype forms. Participants were shown alternate versions of the form so that we could learn what was and wasn't working.

Lending credence to the findings, these studies agreed with each other in almost all respects.

Health Insurance Is Complex—Consumers Dread Shopping

In our testing, we started with open ended questions to assess how easy or difficult it was to shop for coverage prior to seeing the SBC. Few will be surprised that consumers find it very difficult to sort through health plan information. What's critical is to understand just how profound this difficulty is, and to develop the nuanced understanding of consumer difficulties that will allow targeted improvements to health plan information.

In our testing, consumers told us that health insurance was one of the hardest things they shop for. In particular, they highlighted the difficulty of figuring out how much coverage is offered by a plan. Specifically, sorting through a plan's *cost-sharing provisions* was the most difficult aspect of health insurance shopping.

Aside from premiums and copays, many cost-sharing concepts were unfamiliar to consumers. They don't know the meaning of terms like benefit limit, annual limit, or out-of-pocket maximums. Yet these concepts must be used, together with covered services, to understand the overall financial protection offered by a health plan.

Testing allows us to take a nuanced look at these consumer difficulties. As an example, there are *three* separate things that consumers find difficult about coinsurance:

- Many are not sure *who* is responsible for paying the indicated percentage. They are particularly confused when presented with a coinsurance rate of 0 percent or 100 percent.
- Many consumers have poor *numeracy* skills. They have difficulty applying a percentage to a dollar figure.
- They don't know what they have to pay. Coinsurance percentages are applied to the contracted charge between the health plan and the provider called the "Allowed Amount." At the point of shopping for a plan, or even when receiving medical care, this is an unknowable number so there is *no bottom line* for the consumer. Coinsurance of 75 percent might be better than 80 percent coinsurance—depending on those underlying contracted amounts.

While not as frequent, consumers also had difficult understanding some covered service terms, like the difference between screenings and diagnostic tests.

As a result, it is very difficult for consumers to figure out how much coverage is offered by a health plan. Even skilled consumers were leery of committing to a plan, because they were worried about the 'fine print.' Due to these concerns, consumers told us they dread shopping for health insurance coverage.

³We'd like to recognize: California HealthCare Foundation, Commonwealth Fund, Missouri Foundation for Health and NYS Health Foundation.

⁴Consumers Union and People Talk Research, *Early Consumer Testing of New Health Insurance Disclosure Forms*, December 2010 and Consumers Union and Kleimann Communication Group, *Early Consumer Testing of the Coverage Facts Label: A New Way of Comparing Health Plans*, August 2011.

⁵*America's Health Insurance Plans Focus Group Summary*, JKM Research, October 2010 and *America's Health Insurance Plans [and] Blue Cross Blue Shield Association Focus Group Summary*, JKM Research, May 2011 [Report web links at the end of this testimony].

⁶Cognitive interviewing is a technique used to provide insight into learners' perceptions in which individuals are invited to verbalize thoughts and feelings as they examine information.

SBC Helps Consumers

While the SBC does not reduce the underlying complexity of health plans, testing showed it does help consumers make sense of the coverage. In particular, consumers told us they liked:

- Uniform layout of SBC—so they can line up forms for different plans and compare them;
- “Why this matters” information—to provide a sense of how important specific features are;
- Having “exceptions to coverage” all in one place; and
- Coverage Examples—for reasons discussed below.

Coverage Examples Were Transformational

Coverage examples are a new feature, typically not provided in other plan summaries. For selected medical scenarios, these examples show how much the underlying health care costs and how much the plan would pay (Exhibit 1).

Exhibit 1: Coverage Example	
Having a baby (normal delivery)	
<ul style="list-style-type: none"> ■ Amount owed to providers: \$7,540 ■ Plan pays \$5,490 ■ Patient pays \$2,050 	
Sample care costs:	
Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540
Patient pays:	
Deductibles	\$700
Copays	\$30
Coinsurance	\$1320
Limits or exclusions	\$0
Total	\$2,050

Testing revealed that these examples provided consumers with three pieces of information they wouldn't otherwise have:

- How much medical care costs—helps them to avoid underinsuring
- A bottom line showing what the patient owed—rolling up myriad cost-sharing provisions
- What the plan paid towards the services

Testing showed us that this last item was much more important than one would guess. Traditional health plan disclosures focus on what the patient pays towards costs. After a long list of costs paid by patient, some consumers question whether or not health insurance is a good deal.

Showing what the plan paid—especially for an expensive illness like cancer⁷—greatly increased consumers’ willingness to make a health plan selection and increased their confidence in the selection.⁸ It reminded consumers of the benefit that they get from purchasing insurance.

That’s pretty powerful stuff!

Evidence from Polling

Survey evidence reinforces the findings from consumer testing. One nationally representative survey found that an SBC type of benefit ranked the highest among the many provisions in the ACA—showing it is highly valued by consumers.⁹

In order to see how well the SBC worked in practice, Consumers Union conducted our own nationally representative survey to see whether consumers used their new benefit when they shopped for private health insurance in the Fall of 2012—the first season when the benefit was available.¹⁰ We learned:

- Awareness of the new benefit is low. Only about 50 percent of consumers who shopped for or renewed private health insurance coverage recalled seeing the SBC. Rates were even lower for those who shopped for coverage on their own in the non-group market.
- Among shoppers that *did* see the SBC, their impressions were very favorable. Over 50 percent were very or completely satisfied with the specific features of the SBC, with very few expressing any dissatisfaction. When asked to rate the helpfulness of the SBC against other common sources of health plan information, the SBC was rated as helpful most often.
- Few consumers reported seeing the new feature called “Coverage Examples.”

Anecdotal evidence from the fall suggests that insurers may need to make it easier for shoppers and current enrollees to access their SBC, particularly in the non-group market. They may also need to improve quality control to ensure that SBCs are released without errors.¹¹

Who Should Bear the Cost of Complexity?

Complexity has a cost. When consumers can’t confidently compare their health plan options, they may find themselves underinsured or fail to complete enrollment. Under-insured consumers act like uninsured consumers—consuming too little care due to concerns about costs, possibly leading to poorer health and greater medical expenses down the road. And consumer confusion costs money, leading to great use of customer help lines.¹²

In their comments responding to the proposed SBC rule, several insurers were concerned about the cost of producing the SBC form for consumers. At the high end, they estimated it would cost a dollar per enrollee to produce the form.

We can debate what the right number is but for us, it comes down to this: health insurance is necessary for the health and financial security of families. With something this important and this expensive, consumers should *not* be asked to shop with a blindfold on, that is, with an incomplete idea how much coverage they are getting.

Hence, *someone* has to invest the time to craft the reliable, comparative information like that found in the SBC. From a societal perspective, it makes much more sense for the expert health insurer to do it once, providing a clear summary for all future shoppers for the policy. The alternative is for each individual consumer to slog through the same analysis—or giving up and going without coverage or buying a product that doesn’t provide sufficient protection for their family.

⁷During development of the SBC, a breast cancer scenario was tested but not included in the initial requirements for the SBC. Because of the high charges associated with this scenario (roughly \$100,000), this example generated the biggest consumer response among the three that were tested. HHS has committed to including up to four more coverage examples (for a total of six) in future revisions of the SBC.

⁸Consumers Union and Kleimann Communication Group, *Early Consumer Testing of the Coverage Facts Label: A New Way of Comparing Health Plans*, August 2011 and *America’s Health Insurance Plans [and] Blue Cross Blue Shield Association Focus Group Summary*, JKM Research, May 2011.

⁹Kaiser Health Tracking Poll, November 2011.

¹⁰L. Quincy, *Early Experience With A New Consumer Benefit—the Summary of Benefits and Coverage*, Consumers Union, February 2013.

¹¹*Ibid.* As an example, we saw SBCs where maternity was shown as “not covered” in the coverage example but failed to be listed in the box describing non-covered services.

¹²UnitedHealth Group conducted a study which found that it clearer Part D and Medicare advantage products would save an estimated \$4 million/year through reduced consumer calls. Industry wide savings would be greater and consumer satisfaction greater still (as not everyone who is confused call the help line).

And while some insurers and employers have crafted nice looking summaries over the years these have one big problem—they don’t use the same format. And some have failed to promote important loopholes in the coverage.

An estimated 170 million consumers purchase private health coverage today. Many have a choice and would benefit from having a standard method of comparing plans:

- 66 percent of employees whose employer offers coverage have a choice of plans.¹³
- Additionally, many employees have an alternate coverage option through their spouse’s employer.
- Consumers purchasing in the non-group market (approximately 19 million today) also face a choice of plans.

Even those with only one coverage option from their employer benefits from having a consumer-tested, understandable summary that shows them how to use their health plan and stays that same over time, rewarding them for learning to use the Summary.

You can’t have a functioning marketplace until consumers are armed with the information they need to meaningfully compare products. Like the nutrition facts panel on food or the EPA’s miles per gallon sticker on new cars, having a standard description across products greatly facilitates shopping and encourages competition based on the underlying value of the products.

Next Steps for the Summary of Benefits and Coverage

Few consumer disclosures are perfect when initially rolled out. Evidence from testing and our survey suggest that the SBC could be improved in several ways. For example:

- Add more coverage examples, including at least one showing an expensive illness like breast cancer.
- Ensure that the medical costs displayed in the coverage examples represent realistic price levels. The current use of Medicare pricing is too low.
- Test moving coverage examples closer to the front of the form so that more consumers are aware of them.
- Add a row for premium back to the form. While the tested versions contained this information, it was removed in the final rule.¹⁴
- Work with a designer to improve the look and feel of the form.¹⁵
- Engage in activities to increase consumer awareness of the form.
- Improve insurer oversight with respect to compliance with the rule.

Require Consumer Testing and Monitoring of New Disclosures

The value of consumer testing has been firmly established. Unfortunately, there is no uniform Federal policy with respect to pre-testing and monitoring federally-required, consumer-facing disclosures.¹⁶ As a result, many disclosures are not tested or monitored to assess their consumer impact.

Going forward, consumer pre-testing and post-launch monitoring should be required and funded by the governmental entity that requires the disclosure. This effort should be commensurate with the number of consumers expected to view the disclosure. We recommend that all findings from monitoring and testing be made

¹³*Decoding Your Health Insurance: The New Summary of Benefits and Coverage*, Families USA, May 2012.

¹⁴Opponents of premium information argued that it was not specifically required by statute but testing and common sense shows that it is integral to achieving the statutory goal of allowing consumers to “compare coverage.” The NAIC recommendations conveyed to HHS included recommendations for how to include premium information when necessary underwriting information was not available.

¹⁵While the NAIC worked very hard to provide their recommendations to the tri-agencies and successfully engaged a diverse group of stakeholders, a designer has not yet been engaged to professionally improve the look and feel of the form. As this report shows, alternate approaches to layout may further improve consumers’ ability to use the form: http://www.naic.org/documents/committees_b_consumer_information_110505_literacy_review.pdf

¹⁶Impressive work in this area includes CFPB’s the “Know Before You Owe” design and testing efforts with respect to mortgage disclosures (http://files.consumerfinance.gov/f/201207_cfpb_report_tila-respa-testing.pdf) and the redesign of the energy star label for appliances (<http://www.energystar.gov/ia/business/downloads/FTCs%20Appliance20Labeling%20Rule.pdf>).

publicly available, to ensure independence and as an aid in the development of other materials for consumers.

Thank you for the opportunity to comment on this very important consumer benefit.

Submitted by:

LYNN QUINCY,
Senior Health Policy Analyst,
Consumers Union.

Web Links for the SBC Testing Studies

Study Topic	When	Whose Study	Web Link to Study
Pages 1-4 of new health insurance disclosure	Sept-Oct 2010	CU	http://prescriptionforchange.org/wordpress/wp-content/uploads/2011/09/CU_Consumer_Testing_Report_Dec_2010.pdf
		AHIP	http://www.naic.org/documents/committees_b_consumer_information_101012_ahip_focus_group_summary.pdf
“Coverage Facts Label” (pages 5-6)	May 2011	CU	http://prescriptionforchange.org/wordpress/wp-content/uploads/2011/08/A_New_Way_of_Comparing_Health_Insurance.pdf
		AHIP/BCBSA	http://www.naic.org/documents/committees_b_consumer_information_110603_ahip_bcbsa_consumer_testing.pdf
Actuarial Value Concepts	May 2011	CU	http://prescriptionforchange.org/wordpress/wp-content/uploads/2011/10/prescriptionforchange.org_testing_actuarial_value_concepts.pdf

The CHAIRMAN. Thank you very much.

And actually, I was just thinking what Senator—Ranking Member Thune said—84 percent like it. I think it’s, far and away, the most popular thing in the entire Act. Isn’t that true? I won’t go—

Ms. QUINCY. That’s what the Kaiser poll showed.

The CHAIRMAN. Now, Mr. Michael Livermore—as I indicated, Executive Director, Institute for Policy Integrity, New York University School of Law.

STATEMENT OF MICHAEL A. LIVERMORE, EXECUTIVE DIRECTOR, INSTITUTE FOR POLICY INTEGRITY, NEW YORK UNIVERSITY SCHOOL OF LAW

Mr. LIVERMORE. Thank you very much, Mr. Chairman, Senator Thune. It’s a wonderful opportunity to be here and have the opportunity to testify today.

The center that I run at NYU focuses on the use of cost-benefit analysis to evaluate government policy. That’s really our area of expertise. And, as you know, cost-benefit analysis has been around for decades. And the question it asks is whether what we’re buying for the public is worth the price tag that we’re asking them to pay. That’s the fundamental question.

Today, of course, we’re here to discuss provisions of the Affordable Care Act, requiring insurance companies to disclose, in a standard format, information to potential customers about their plans. The idea is to give consumers more information so they can make better health insurance decisions.

Now, naturally, there’s going to be some costs associated with standard disclosure. Agencies have estimated we’re talking around

\$70 million per year, give or take. But, looking at the cost of the SBC, alone, without attending to the benefits, is economically meaningless. The question is not whether there are some costs, in an absolute sense, but whether the benefits justify those costs. And compared to the potential benefits of improved consumers' decision-making in the health insurance market, the costs of the SBC are going to be utterly swamped.

Health insurance is a massive market in the United States; and changes to the way individuals, families, and businesses make decisions are likely to have significant consequences. Even a small improvement in consumer decisionmaking can generate very large economic returns in this market. More and better information means consumers can make better decisions, and it helps them find insurance products that fit their needs.

There's a substantial body of research in behavioral economics, psychology, in cognition, about consumers make decisions. Based on this research, we can see that health insurance is a context that provides particularly high challenges to consumers. It involves long-term probabilistic, risk-based assessments of people's health, there's a long time lag between buying insurance and when you actually need to rely on it to pay for care—there can be. And you don't make these types of health insurance decisions very often, so you don't build the kind of experience base that allows you to make smart decisions.

Each of these, alone, would make the decision difficult for consumers, but, collectively, they really create major challenges to consumers maximizing their benefit. So, this disclosure really helps, in that respect.

A second benefit is the time-saving to consumers by having a standardized, comparative document that they can utilize. Time is money in the healthcare selection business, just as everywhere else in life. No one would characterize collecting and comparing insurance plans as a leisure activity. It's work. It's no fun. So, for time-pressed Americans, who have responsibilities to parents and families, communities, children, in addition to the hours they spend at work, anything that we can do, in public policy, to free up leisure time has real economic value.

This information is also going to help value-conscious consumers get the most bang for their buck. And smarter, more informed consumers means that insurance companies will waste less time and money designing and promoting products that don't maximize values for consumers—the dollar—the value that they get for their dollar.

Consumers who also understand their plans better are in a better position to take advantage of coverage that's offered, so they can access healthcare services when they need them, which is going to lead to better health. Especially for preventative care, we're talking about long-term savings for the American economy.

Finally, a straightforward, standardized disclosure creates incentives for insurance companies to compete on price, benefits, and quality. So, by helping to improve consumer decisionmaking, the SBC creates a virtuous cycle, where consumers can make better choices between plans that are already on offer, but also creates in-

centives for insurance companies to provide better plans and better choices in the future.

So, consumer disclosure has proven extremely important in a variety of different marketplaces. It's hard to imagine going to the grocery store and not being able to look at nutrition labels or buy a new car without having access to fuel economy labels. And health insurance, if anything, is a context that screams out for this kind of disclosure requirement. It's exactly the kind of context where consumers have the most to benefit.

Now, one of the most promising features of the rule that I saw, the SBC rule, as it exists, is that the agencies have committed to continue testing and making the rule even better. There are many areas where improvement is certainly possible. Expansion of the coverage examples is one area that maybe we'll have an opportunity to discuss some more.

But, in general, the rule does a very good job. It's a very first—good first cut, and it puts consumers in a much better position than they have been in the past.

[The prepared statement of Mr. Livermore follows:]

PREPARED STATEMENT OF MICHAEL A. LIVERMORE, EXECUTIVE DIRECTOR,
INSTITUTE FOR POLICY INTEGRITY, NEW YORK UNIVERSITY SCHOOL OF LAW

Mr. Chairman, thank you for the opportunity to testify before the Senate Committee on Commerce, Science, and Transportation today. My name is Michael Livermore and I am the Executive Director of the Institute for Policy Integrity at New York University School of Law. Policy Integrity is a non-partisan think tank dedicated to improving the quality of government decisionmaking through advocacy and scholarship in the fields of administrative law, economics, and public policy.

The focus of my testimony is section 2715 of the Public Health Service Act, as added by the Patient Protection and Affordable Care Act, which requires uniform disclosure standards in providing benefits and coverage explanation to insurance applicants and enrollees. On February 14, 2012, a Final Rule was published by the Department of Health and Human Services, Department of the Treasury, and Department of Labor on Summary of Benefits and Coverage and Uniform Glossary (the SBC Rule) pursuant to this section.

My testimony will make three basic points:

Analysis conducted by the agencies prior to promulgation of the final rule shows that the benefits of section 2715, which included both improved consumer decisionmaking and improved health outcomes, will outweigh the costs, likely by a substantial margin.

The substantive requirements of section 2715 and the SBC Rule accord with available evidence on consumer decisionmaking. In particular, the use of examples and the standardization of disclosure of benefits and coverage information will empower consumers to process information about plan alternatives to make more informed choices that better match their risk preference and long-term needs.

The agencies have committed to continually testing, updating, and improving the SBC Rule, which will lead to increased performance and greater net benefits over time. Because many regulatory contexts involve conditions of uncertainty, the agencies have adopted an appropriate policy of moving forward with well-justified measures while continually revising and improving their regulatory requirements in the face of new information.

The Benefits of Section 2715 and the SCB Rule Outweigh the Costs

In their final rule implementing the requirements of section 2715, the agencies find that benefits are likely to outweigh costs. Annual compliance costs are estimated at \$73 million. Given the massive size of the private health insurance market

in the United States, even a small improvement in consumer decisionmaking would overwhelm this relatively modest cost.¹

The agencies cite several ways in which the rule will benefit consumers. First, improved access to information will allow consumers to “make better coverage decisions, which more closely match their preferences with respect to benefit design, level of financial protection, and cost.”² Improved consumption decisions will result in increased consumer satisfaction.

The factual premise underlying this conclusion is that, without the rulemaking, consumers would not have access to, and process, an optimal amount of information when making health insurance decisions. There are good reasons to believe that this is correct. Choosing a health insurance plan is a complex decision, involving a wide range of probabilistic judgments on the part of consumers. This decision is made infrequently, and any feedback that consumers receive is attenuated by time and intervening circumstances. Firms will not have the incentive to present consumers with the socially optimal amount of information, in the form most easily processed, if consumers cannot readily predict their satisfaction levels based on product choices. Health insurance is, therefore, a context that is very well suited to a government disclosure requirement meant to improve consumer decisionmaking.³

Second, the rule is expected to “benefit consumers by reducing the time they spend searching for and compiling health plan and coverage information.”⁴ Search time reduction can be a substantial savings and can be as valuable as pecuniary savings or improved health. Collecting information about health insurance plans is not a leisure activity; it is a form of work that carries disutility: hourly wages serve as a reasonable proxy for the rate at which individuals are willing to trade leisure for monetary compensation. The agencies cite research by the National Bureau of Economic Research that shows that making health insurance decisions, in particular, involves substantial search costs.⁵ This type of information gathering activity is also redundant with similar efforts undertaken across the economy by other individuals: if a trustworthy agent can act on behalf of the American public to compile relevant information in an easily accessible format, it represents a real economic savings.

Third, the rule is anticipated to “result[] in cost-savings for some value-conscious consumers who today pay higher premiums because of imperfect information about benefits.”⁶ This consumer benefit could be interpreted as a transfer from insurance companies to their consumers, rather than a pure efficiency gain. However, the existence of these types of rents creates incentives for firms to compete, in an economically unproductive way, to capture them, at the very least through advertising. Equally problematic, from an efficiency perspective, would be attempts by insurance companies to increase these rents through product design, which not only involves the inefficient (from a social perspective) allocation of firm resources, but results in a marketplace with distorted consumer choices.

Finally, by “making it easier for consumers to understand the key features of their coverage,” the rule is anticipated to “enhance consumers’ ability to use their coverage.”⁷ If consumers are better able to access health care services when they need them, it can lead to substantial health benefits, which has obvious economic value. Increased utilization of preventative health care services, in particular, can lead to social value if long-term chronic or catastrophic health outcomes can be avoided through early medical intervention.⁸

An additional, longer-term benefit of the rule, which is alluded to in the final rule-making document, is that “health insurance issuers and employers may face less pressure to compete on price, benefits, and quality” if consumers lack appropriate

¹ For general background on the role of cost-benefit analysis in administrative decisionmaking, see RICHARD L. REVESZ & MICHAEL A. LIVERMORE, *RETAKING RATIONALITY: HOW COST-BENEFIT ANALYSIS CAN BETTER PROTECT THE ENVIRONMENT AND OUR HEALTH* (2008). This testimony is based on comments submitted by the Institute for Policy Integrity to the Department of Health and Human Services on July 6, 2011, http://policyintegrity.org/documents/IPI_Letter_to_HHS_7.6.11.pdf.

² 77 Fed. Reg. 8682.

³ For an overview of recent scholarship concerning how government provision of information and improved “choice architecture” can facilitate better consumer decisionmaking, see RICHARD H. THALER & CASS R. SUNSTEIN, *NUDGE: IMPROVING DECISIONS ABOUT HEALTH, WEALTH, AND HAPPINESS* (2008).

⁴ 77 Fed. Reg. 8682.

⁵ 77 Fed. Reg. 8681.

⁶ 77 Fed. Reg. 8682–83.

⁷ 77 Fed. Reg. 8683.

⁸ Of course, some preventative care interventions are more justified on cost-effectiveness grounds than others. See generally, Joshua T. Cohen, *Does Preventive Care Save Money? Health Economics and the Presidential Candidates*, 358 N. ENGL. J. MED. 881 (2008).

information.⁹ The consequence is a marketplace with a distorted set of product choices. By helping improve consumer decisionmaking, the rule can facilitate a virtuous circle in which consumer satisfaction is increased not only through better choice between existing products, but also through the creation, and offer for sale, of insurance products that better conform to consumer preferences.

While the agencies provide a qualitative discussion of the benefits of the rulemaking, there is no quantitative estimate of regulatory benefits. Since President Reagan issued Executive Order 12291 in 1981, there has been a stated policy within the Executive of quantifying and monetizing regulatory costs and benefits, and the agencies recognize that the current Executive Order governing regulatory review “emphasizes the importance of quantifying both costs and benefits.”¹⁰ The types of benefits anticipated by the rule, including increased consumer satisfaction, improved health outcomes, and time savings are all, in principle, amenable to quantification and monetization.

Although ongoing analysis of the effects of the rulemaking, including quantification and monetization of regulatory costs and benefits, is appropriate (as discussed below), the agencies followed a prudent path by moving forward with this regulatory action and avoiding unnecessary delay in the service of additional ex-ante analysis. Executive Order 12866 (still operative) encourages agencies to utilize “alternatives to direct regulation, including . . . providing information upon which choices can be made by the public,”¹¹ and Executive Order 13563 encourages agencies to “consider regulatory approaches that reduce burdens and maintain flexibility and freedom of choice for the public . . . includ[ing] disclosure requirements as well as provision of information to the public in a form that is clear and intelligible.”¹² The difficulty of predicting the effects of disclosure requirements ex-ante, however, sometimes interferes with the ability to quantify and monetize benefits in advance. Nevertheless, the benefits of disclosure requirements will often exceed their costs, because they are among the least restrictive forms of regulation. Furthermore, the costs of alternative disclosure requirements are likely to be similar: the important question is often not whether some form of disclosure is economically justified, but how to design the disclosure to maximize its net benefits. In these cases, the inquiry associated with cost-benefit analysis collapses into a technical exercise of how best to design the disclosure to improve consumer decisionmaking.

The Rule Is Based on the Available Evidence Concerning Consumer Decisionmaking

Extensive research in the fields of behavioral economics, psychology, and cognition show that it is not enough to simply “provide information.”¹³ Consumers are known to have cognitive biases that affect their decisionmaking. Academic research on how individuals absorb and process information can inform the design of government policy to deliver the best possible results for the American Public.¹⁴

Professor Cass Sunstein, until recently the administrator of the Office of Information and Regulatory Affairs, has argued that even seemingly small alterations in presentation format can “highlight different aspects of options and suggest alternative heuristics” that have demonstrable effects on people’s behavior.¹⁵ Interventions taking advantage of these effects can be strikingly cost-benefit justified, since these psychological cues typically cost very little.¹⁶

OIRA has issued guidance on the use of disclosure to achieve regulatory ends.¹⁷ According to this guidance document, summary disclosure should be concise and straightforward to “highlight the most relevant information” and to “increase the likelihood that people will see it, understand it, and act in accordance with what they have learned.”¹⁸ Disclosure should avoid technical language or extraneous information that may be inaccessible to the average reader. OIRA has cautioned that “[u]nduly complex and detailed disclosure requirements may fail to inform con-

⁹ 77 Fed. Reg. 8681.

¹⁰ 77 Fed. Reg. 8680.

¹¹ 58 Fed. Reg. 51736.

¹² 76 Fed. Reg. 3822.

¹³ Christine Jolls *et al.*, *A Behavioral Approach to Law and Economics*, in CASS R. SUNSTEIN, *BEHAVIORAL LAW AND ECONOMICS* 13, 42 (Cass R. Sunstein ed., 2000).

¹⁴ See *e.g.*, Judith H. Hibbard, *et al.*, *Informing Consumer Decisions in Health Care: Implications from Decision-Making Research*, 75 *MILBANK Q.* 395 (1997).

¹⁵ Cass R. Sunstein, *Introduction*, *BEHAVIORAL LAW AND ECONOMICS* 1, 1.

¹⁶ Hunt Allcott, *Beliefs and Consumer Choice* (MIT Working Paper, Nov. 2010), available at <http://web.mit.edu/allcott/www/papers.html>.

¹⁷ Memorandum from Cass R. Sunstein, Administrator, Office of Information and Regulatory Affairs to Heads of Exec. Dep’ts and Agencies 4 (June 18, 2010).

¹⁸ *Id.* at 3.

sumers” because the disclosure “may not be read at all, and if it is read, it may not have an effect on behavior” because it is poorly understood.¹⁹

Presenting information in this manner coincides with the statutory mandate to account for linguistic and educational barriers to health and literacy.²⁰ There are large variations in the “degree to which individuals have the capacity to obtain, process and understand basic health information.”²¹ The Center for Health Care Strategies (CHCS) notes that “[w]hile low health literacy is found across all demographic groups, it disproportionately affects non-white racial and ethnic groups; the elderly; individuals with lower socioeconomic status and education; people with physical and mental disabilities; those with low English proficiency (LEP); and non-native speakers of English.”²² Indeed, low health literacy has been estimated to cost the U.S. economy between \$106 billion and \$236 billion annually.²³ Presenting information in a format that is easy to understand and to act on will allow a wide range of consumers to make more informed insurance choices. If the SBC Rule prevents even a small portion of the costs of low health literacy, it will be extremely well justified in economic terms.

The SBC Rule was developed after a consultation process facilitated by a working group convened by the National Association of Insurance Commissioners that was composed of “a diverse group of stakeholders” and that “considered the results of various consumer testing sponsored by both insurance industry and consumer associations.”²⁴ The rule references two focus group exercises, one conducted by America’s Health Insurance Plans (a trade association) and the other conducted by Consumers Union.²⁵ This testing supports the agencies’ conclusion that the format of the disclosure information helped consumers make informed choices about their options.

In addition to the standardized, simplified language used to disclose plan features, two benefits scenarios are included to illustrate plan differences. The common scenarios partially utilize the availability heuristic—people’s tendency to assess risk depending on how readily examples come to mind. The availability heuristic can, in this context, help counter detrimental overconfidence. Consumers tend to be over-optimistic regarding risks to life and health, which can lead them to select under-inclusive insurance coverage.²⁶ If people can easily think of relevant examples, they are far more likely to be concerned about those risks than if they cannot. Presenting common scenarios can encourage a realistic weighing of these scenarios in insurance purchasing.

The Agencies Plan to Continue Testing and Improving its Disclosure Format

To maximize the benefits of the regulatory system, it is important to continually monitor and update regulatory programs in light of new information.²⁷ OIRA has found that this may be particularly important “[w]ith respect to summary disclosure [because] agencies will often be able to learn more over time.”²⁸

Section 2715 requires a continual process “review[ing] and update[ing]”²⁹ the effects of the SBC Rule. The agencies have committed to measuring the effect of disclosure on behavior through ongoing empirical analysis and to modifying the standards accordingly. In particular, the agencies are “taking a phased approach to implementing the coverage examples and intend to consider additional feedback from con-

¹⁹ Office of Information and Regulatory Affairs, 2010 Report to Congress on the Benefits and Costs of Federal Regulations and Unfunded Mandates on State, Local, and Tribal Entities, Appendix D: Disclosure and Simplification as Regulatory Tools 55 (2010).

²⁰ § 2715(b)(2).

²¹ Stephen A. Somers & Roopa Mahadevan, *Health Literacy Implications of the Affordable Care Act* 4, Center for Health Care Strategies, Inc., November 2010 (report commissioned by the National Institute of Medicine).

²² Center for Health Care Strategies, Inc., *Health Literacy Implications of the Affordable Care Act* 1, Missouri Foundation for Health’s Health Summit, Dec. 9, 2010, available at www.mffh.org/mm/files/Summit_Mahadevan_handout.pdf.

²³ *Id.*

²⁴ 77 Fed. Reg. 8670.

²⁵ 77 Fed. Reg. 8674.

²⁶ See generally David A. Armor and Shelley E. Taylor, *When Predictions Fail: The Dilemma of Unrealistic Optimism*, in *HEURISTICS AND BIASES: THE PSYCHOLOGY OF INTUITIVE JUDGMENT* (Dale Griffin and Daniel Kahneman eds., 2002).

²⁷ Michael Greenstone, *Toward a Culture of Persistent Regulatory Experimentation and Evaluation*, in *NEW PERSPECTIVES ON REGULATION* 111, 113 (David Moss and John Cisternino eds., 2009).

²⁸ OIRA 2010 REPORT, *supra* note 19 at 101.

²⁹ § 2715(c).

sumer testing in the future.”³⁰ Revisions should be made “to the extent. . .the evidence warrants,”³¹ and it should be recognized that empirical findings may support retention of the agencies’ initial design choice.

Best practices require testing of potential disclosure formats,³² and as OIRA guidance documents make clear, testing should be a major component of any label evaluation process.³³ The agencies now have the opportunity to test the SBC design in market conditions. Questions that should be asked include “whether users are aware of the disclosure, whether they understand the disclosure, whether they remember the relevant information when they need it, whether they have changed their behavior because of the disclosure, and, if so, how.”³⁴

Conclusion

The SBC Rule is an important move towards increased transparency in the health insurance market, with the ultimate aim of improving consumer welfare via informed consumer decisionmaking. Given the relatively low costs of implementing the rule (compared to the size of the market and potential benefits), a primary focus should continue to be testing and improving the design of summary disclosure and labeling to maximize the benefits of disclosing information. Consumers must be able to select insurance policies that better match their preferences and unique health needs if consumer satisfaction and improved health outcomes are to be realized. The current rule is likely to yield substantial net benefits, and the costs of delay associated with further pre-implementation analysis is not justified: the agencies have appropriately chosen to move forward with a rulemaking now, while committing themselves to further ex-post study. The SBC template is grounded in sound behavioral, economic, and psychological understandings of how consumers make choices, and further research, and refinement, will continue to increase the utility of this important consumer protection measure.

The CHAIRMAN. That’s it?

Mr. LIVERMORE. Yup.

The CHAIRMAN. OK.

Mr. LIVERMORE. Thank you.

The CHAIRMAN. All right.

Peggy O’Kane, President, National Committee for Quality Assurance.

STATEMENT OF MARGARET O’KANE, PRESIDENT, NATIONAL COMMITTEE FOR QUALITY ASSURANCE

Ms. O’KANE. Thank you, Mr. Chairman, and thank you, Ranking Member Thune. And I’m very pleased to be here today for this important hearing on increasing transparency in healthcare.

My name is Margaret O’Kane, and I’m President of the National Committee for Quality Assurance. We’re an independent nonprofit organization founded in 1990, to improve quality and value in healthcare through measurement, transparency, and accountability; so it’s right there in our founding reason for being. We accredit health plans, and we measure the quality of both the care that they preside over and the members’ experience.

Our nation is making great strides in using transparency to improve quality and value in healthcare. And, of course, value means quality—the amount of quality or health that you get for your healthcare dollar. This includes public reporting of standardized performance measures, performance-based accreditation, and Affordable Care Act innovations, like the standardized Summary of

³⁰ 77 Fed. Reg. 8674.

³¹ *Id.*

³² See Sunstein, *supra* note 17 at 6.

³³ OIRA 2010 REPORT, *supra* note 19 at 56.

³⁴ Sunstein, *supra* note 17 at 5.

Benefits and Coverage, which the other two have already spoken about so eloquently.

The ACA provision linking Medicare Advantage bonus payments to performance has been especially effective, and recent research shows, beneficiaries are now more likely to pick high-value plans. In fact, we've seen Medicare Advantage plans' quality results increasing significantly since the ACA linked bonus payments to performance scores.

The ACA will further harness transparency to promote quality and value through State health insurance exchanges. Exchanges represent a unique opportunity to engage consumers in using transparent quality and cost data together to find the best value. And, of course, many consumers haven't had a choice of plans for a long time, so this is actually a real marketplace that the exchange will create.

Value means more than just low premiums, which may reflect low quality or high cost-sharing barriers to care. Value is the quality of the health and well-being you get for the total cost you pay, which includes premiums, copays, and deductibles.

Helping consumers find the best value requires designing exchanges in ways that make our cost and quality information easy to use. If done effectively, this will also cause plans to compete, based on value, not just cost, and further drive consumer engagement and market performance.

The complexity of cost and quality information can quickly overwhelm consumers. So, how exchanges present the data matters a great deal. Groups like Consumer Reports and behavioral economists, like Mr. Livermore's center, are uniquely skilled in developing ways to communicate complex information effectively to consumers. Applying lessons from the science of behavioral economics and choice architecture can also help consumers to get the best value plans.

In addition, the Federal Government is developing a quality rating system for exchanges, and we have high hopes that it will help consumers make more informed purchasing decisions. Up until now, large employers, the Federal Government, and many State Medicaid programs have been important users of quality information, and have pushed for and rewarded quality results. However, public reporting to consumers has had minimal impact. Exchanges have enormous potential to change that. We are particularly encouraged by our research that shows consumers, especially the uninsured who will be shopping for exchange coverage, want cost and quality information when they're choosing plans.

Given the many challenges in establishing exchanges, few states are yet actively working to use transparency to engage patients on cost and quality, and HHS has yet to issue rules on ACA activities to improve quality. Once exchanges are functioning, however, Congress should closely monitor Federal and State efforts, and require HHS to report on them, to ensure that this important opportunity to drive a value agenda is not lost.

Despite the progress we are making, there are still important gaps in transparency. For example, we're not able to compare quality in fee-for-service Medicare with Medicare Advantage plans, as

MEDPAC has recommended. We need transparency on the prices of healthcare services that drives costs.

I brought my *Time* magazine. I don't know how many—

The CHAIRMAN. Yes.

Ms. O'KANE.—of you have seen. This guy's been on every TV show that I watch.

The CHAIRMAN. It's must-reading, isn't it?

Ms. O'KANE. It really is. And I think it's very salient to consumers. Consumers are really shocked when they read this. So, I think it's kind of a golden opportunity to educate people more about what healthcare costs, and help them become part of driving the solution.

We need to make transparency and consumer choice part of a broader value strategy that includes payment and delivery system reforms. We also must do more to understand how transparency can better engage consumers in taking a more active role in their own health.

But, at least we're heading in the right direction. And I think transparency, to me, is foundational to everything we do in public policy.

So, thank you so much for the opportunity to be here today.

[The prepared statement of Ms. O'Kane follows:]

PREPARED STATEMENT OF MARGARET O'KANE, PRESIDENT,
NATIONAL COMMITTEE FOR QUALITY ASSURANCE

Chairman Rockefeller, Ranking Member Thune, distinguished committee members, thank you for inviting me to this important hearing on increasing transparency in health care. I am Margaret O'Kane, President of the National Committee for Quality Assurance. NCQA is an independent, nonprofit organization founded in 1990 to improve quality and value in health care through measurement, transparency and accountability.

Our nation is making great strides in using transparency to improve quality and value in health care through public reporting of standardized performance measures, performance-based accreditation and Affordable Care Act (ACA) innovations like the standardized Summary of Benefits and Coverage. The ACA provision linking Medicare Advantage bonus payments to performance has been especially effective and recent research shows beneficiaries are more likely to pick high-performing plans. In fact, we have seen Medicare Advantage plans' quality results increasing significantly since the ACA linked bonus payments to performance scores.

The ACA will further harness transparency to promote quality and value through state health insurance Exchanges. Exchanges represent a unique opportunity to engage consumers in using transparent quality and cost data together to find the best value. Value means more than low premiums, which may reflect low quality or high cost-sharing barriers to care. Value is the quality of the health and well-being you get for the total cost you pay, which includes premiums, copays and deductibles.

Helping consumers find the best value requires designing Exchanges in ways that promote competition among plans based on value, rather than premiums alone. The ACA requires a 'quality rating system' for Exchange plans that once deployed should be a strong step towards helping consumers find high-value plans. In addition, building Exchanges to promote value requires Web portals and other outreach materials that make cost and quality information easy to find and use. The complexity of the information can quickly overwhelm consumers, so how Exchanges present data matters a great deal. Groups like Consumer Reports are uniquely skilled in developing approaches to communicate this information effectively to consumers. Applying lessons from the science of behavioral economics and "choice architecture" can also help guide consumers to plans offering the best value.

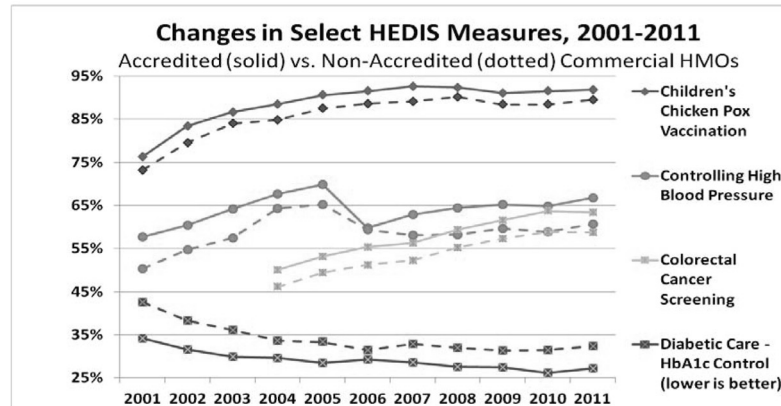
Up until now, large employers, the Federal government and many state Medicaid programs have been important users of quality information and have pushed for quality results. However, public reporting of cost and quality information to consumers has, thus far, had minimal impact. Exchanges have enormous potential to change that. We are particularly encouraged by our research finding that con-

sumers—especially the uninsured, who will be shopping for Exchange coverage—want cost and quality information when choosing plans and providers.

Given the many challenges in establishing Exchanges, few states are currently working on all the potential strategies to use transparency to engage consumers on cost and quality. Once the Exchanges get past the immediate job of getting enrollment systems into place, however, Congress should encourage both Federal and state Exchanges to support innovation and consumer engagement using the many potential strategies available. Congress should also consider having HHS report on Exchange progress on transparency.

Despite the progress we are making, there are still important gaps in transparency. For example, we are not able to effectively compare quality in Medicare fee-for-service with Medicare Advantage plans, something MedPAC has recommended to change.¹ We need much greater transparency on the prices of health care services that drive costs. We must make transparency and consumer choice part of a broader value strategy that includes payment and delivery system reforms. We also must do more to understand how to use transparency to better engage consumers in taking a more active role in their own health and health care.

Public Reporting of Standardized Measurement: There is now widespread use of standardized, audited performance measures like the Healthcare Effectiveness Data and Information Set (HEDIS®)² and the Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS®).³ For 20 years, we have publicly reported results from HEDIS, the most widely used and respected performance measurement set in health care. HEDIS includes more than 70 measures of proven, effective care—and of waste that increases costs and harms patients. CAHPS measures patient experience, such as whether patients get care when they need it; whether physicians listen to patients and explain things in a way they can understand; and whether customer service is helpful and respectful.



More than 125 million enrollees (2 of every 5 Americans) are enrolled in a health plan that submits audited clinical quality and patient customer experience data to NCQA. NCQA translates that data into health plan “report cards” that everyone can see for free on the www.ncqa.org website. We also use the data to publish plan rankings in *Consumer Reports* magazine and to develop our annual State of Health Care Quality Report.⁴ Measuring and publicly reporting results are essential for driving, and holding plans accountable for, needed improvement in quality and cost. The result is dramatic improvement over time in areas like optimal care for diabetes and hypertension—saving both lives and money.

¹MedPAC Report to Congress, March 2010: http://medpac.gov/documents/Mar10_EntireReport.pdf.

²HEDIS® is a registered trademark of NCQA.

³CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ), which oversees the survey.

⁴<http://www.ncqa.org/Portals/0/State%20of%20Health%20Care/2012/SOHC%20Report%20Web.pdf>

Estimated Savings if All Plans Performed as Well as the Top 10%

MEASURE	AVOIDABLE HOSPITAL COSTS
Breast Cancer Screening	\$329 million–\$332 million
Cholesterol Management	\$935 million–\$2.1 billion
Controlling High Blood Pressure	\$1.4 million–\$2.5 billion
Diabetes Care—HbA1c Control	\$294 million–\$614 million
Osteoporosis Management	\$12.4 million–\$32 million
Persistent Beta-Blocker Treatment	\$5.5 million–\$30 million
Smoking Cessation	\$831 million–\$900 million
<i>TOTAL</i>	<i>\$2.4 billion–\$6.5 billion</i>

Performance-Based Accreditation: HEDIS and CAHPS are essential components of NCQA's performance-based Health Plan Accreditation program that measures and publicly reports on the quality of care and patient experience that plans deliver. More than 136 million Americans are in NCQA-Accredited plans, a 30 percent increase since 2009. Most state Medicaid programs also require or recognize NCQA Accreditation, as does the Medicare Advantage program and the Federal Employees Health Benefit Program. The ACA specifically requires all Exchange plans to have accreditation, based on the NCQA model.

Transparency & the Affordable Care Act

The ACA includes several important transparency advances that will promote quality and value. The standardized Summary of Benefits and Coverage is already making it easier for consumers to compare plan benefits and costs to identify affordable coverage, a critical first step toward quality care. The ACA further promotes transparency through Medicare Advantage performance-based bonuses, state Exchange accreditation and public reporting requirements.

Medicare Advantage Star Ratings: The ACA requires using transparency to drive Medicare Advantage improvements through bonuses to plans based on a publicly reported 5-Star Rating system of clinical quality and patient experience. Most states also now use pay-for-performance systems to drive improvements in Medicaid. In just the two first years of the Medicare Advantage bonus system, more than 25 percent of plans have improved their HEDIS scores and the number of highest-rated 5-Star plans has increased from 3 to 11. Medicare posts Star Ratings on the www.medicare.gov plan finder to help beneficiaries make informed enrollment decisions. The plan finder also flags consistently poor performing plans and discourages beneficiaries from enrolling in them.

Recent research shows that Medicare beneficiaries are more likely to pick plans with higher star ratings. The study found that a one star increase was linked to a 9.5 percent greater likelihood of enrollment for new beneficiaries and a 4.5 percent greater likelihood for those switching plans.⁵ In short, public reporting is helping consumers find high value plans, which should lead to better care for beneficiaries and will further encourage those plans to improve quality and lower costs.

We believe Star Ratings could have more impact if the plan finder listed highest quality plans first instead of listing plans with the lowest estimated beneficiary costs first, as it does now. Research shows “what consumers see *first* will frame their understanding of the rest of information—in effect, creating a mental model for them . . . (that) *influences* the consumer's final decision.”⁶

Building State Health Insurance Exchanges to Promote Value: One of the ACA's most important transparency advances begins this fall, when health insurance Exchanges open for enrollment. Exchanges have great potential to realign market forces if designed to promote competition among plans based on value.⁷ This marks substantial change from the current insurance market, which encourages competi-

⁵ Howell, Reid, Shrank, Association Between Medicare Advantage Plan Star Ratings and Enrollment, *Journal of the American Medical Association*, January 2013 <http://jama.jamanetwork.com/article.aspx?articleid=1557733>

⁶ Choice Architecture: Design Decisions that Affect Consumers' Health Plan Choices, Kleimann Communication Group and Consumers Union, July 2012, http://www.consumersunion.org/pdf/Choice_Architecture_Report.pdf

⁷ Building State Exchanges To Get Better Value, National Committee for Quality Assurance, 2012, <http://www.ncqa.org/PublicPolicy/Exchanges.aspx>

tion based on low premiums alone that may reflect poor quality or high cost-sharing barriers to care.

Importantly, the law also requires the Secretary to develop a ‘Quality Rating System’ for Exchange plans. NCQA is supporting CMS in the work on this new rating system—under the leadership of Booz Allen Hamilton and in collaboration with Pacific Business Group on Health. We have high hopes that it will be a critical tool for Exchanges to help consumers make more informed purchasing decisions.

Health plans have many tools they can use to promote quality.

- They can use “value-based insurance design,” or “smart cost-sharing” that reduces barriers to prevention and good management of chronic conditions, averting costly complications.
- They can develop networks and encourage enrollees to use high-quality providers.
- They can remind enrollees and providers about important needs like routine screening and prescription refills.
- They can promote shared decision making to encourage patients and providers to make informed treatment choices together, based on objective, current science on the pros and cons of various options.
- They can promote quality by supporting and encouraging enrollees to get care in recognized PCMHs and ACOs, delivery system reforms focused on improving cost and quality.

Today, cost and quality vary widely among health plans because people rarely help understanding plan value. The problem is compounded because people often believe that more services automatically mean better care (rather than waste and the potential for harm), or that more expensive care is always more effective. This is not true. High quality care is not always the most expensive care for a number of reasons. Expenses may be driven up by unnecessary utilization or by high prices.

Because higher costs do not necessarily lead to higher quality, it is critical to educate consumers on the concept of value and to encourage them to consider both cost and quality data when selecting plans and providers. Informed consumers can help elevate the importance of value in health care by shopping for and choosing plans and providers with the highest quality and lowest costs.

Consumers Want Transparent Cost & Quality Information: NCQA research with the California Healthcare Foundation found that with help, consumers quickly understand that quality does not necessarily cost more—and that it can cost less.⁸ Consumers generally need help to understand this, as it is not intuitive for most people. However, once consumers do understand it, they are greatly interested in using cost and quality information together to help them select a health plan or physician organization. We also found that the people most interested in this information are the uninsured who will be accessing health care coverage through the Exchanges.

Exchanges can advance transparency on cost and quality by:

- Helping Exchange shoppers understand value.
- Helping Exchange shoppers find high-value plans.

There are additional important principles Exchanges should follow to help consumers make the most of transparent cost and quality information. Exchanges need to:

- Present information to consumers as simply as possible. Studies and experience shows that too much information can bog down the enrollment process or prevent someone from choosing a plan.
- Build from existing measures and data collection systems to ensure straightforward and efficient implementation. This will help align efforts to improve quality and provide information on performance to consumers and regulators, limiting the burden on states, plans and the federal government.
- Limit data collection to data that has a clear use; there is considerable cost for reporting unused data.
- Add more information, new measures and quality improvement and assurance strategies over time. Give stakeholders the opportunity to comment on direction, and give plans and states the opportunity to implement system changes.

⁸Value Judgment: Helping Health care Consumers Use Quality and Cost Information, <http://www.ncqa.org/Portals/0/Public%20Policy/CHCF%20ValueJudgmentQualityCostInformation.pdf>

Helping Exchange Shoppers Understand Value: One of the most important things Exchanges can do to promote value is help shoppers understand the need to look beyond premiums to total out-of-pocket costs and quality ratings. Many Exchange shoppers do not currently have insurance and may have low health literacy and scant knowledge about total coverage costs or how to evaluate plan quality. Exchanges that address this information gap will help people find plans that produce better outcomes at lower costs.

Exchange shoppers need to understand copays and deductibles in addition to premiums. In the Massachusetts health Exchange, for example, many enrollees chose plans based on low premiums alone, only to discover when seeking care that they must also pay deductibles and copays. Cost sharing may be significant in the lower-premium Silver and Bronze plans that will attract many modest-income Exchange shoppers, but high cost sharing discourages people, especially those with modest incomes, from getting care.^{9 10} When cost sharing discourages use of necessary, cost-effective care, the result can be expensive, preventable problems. The failure to treat preventable problems up front will continue to drive up health care costs and make coverage difficult to afford.

Shoppers also are not likely to know that Exchange plans must report on measures of clinical quality (like the HEDIS measures) and on “experience of care” measures (like the CAHPS measures). Exchanges that help consumers understand how to use total cost and quality data will see more of them choosing high-value plans, and encourage insurers to compete on improving both cost and quality scores. That will maximize consumer-driven market forces to promote better value.

Helping Exchange Shoppers Find Value: Once Exchange shoppers understand the importance of total cost and quality, the next step is making it easy for shoppers to find and use this information when they choose a health plan. Exchanges can accomplish this by using Web portals and report cards that employ choice architecture.

Most shoppers will not know how to assess complex cost and quality data, even if they understand the importance of total cost and quality. Nor will they want to spend a lot of time evaluating plan choices. By structuring choices properly using choice architecture, shoppers will not need to understand every detail and still end up in high-value plans.

Report Cards and Web Portals: Exchanges Web portals and other tools will help shoppers evaluate plans. How Exchanges craft these tools can have an enormous impact on whether shoppers choose high-value plans.

Exchanges should “feature quality information as prominently as costs,” says Informed Patient Institute Executive Director Carol Cronin. Cronin analyzed 70 health plan report cards for AARP and found that the most useful ones “roll up” quality measures into a single score that consumer can interpret “at a glance.”¹¹ They also offer more details for consumers who want to dig deeper.

To ensure that Web portals and report cards promote value, Exchanges should:

- Present easy-to-understand plan ratings that combine quality and cost rankings (e.g., through the to-be-developed Federal Quality Rating System).
- Provide detailed (but easy to understand) plan ratings (e.g., how well plans help enrollees “Stay Healthy,” “Get Better” and “Live With Illness”).
- Make it easy to see which plans are better at providing high-quality care, like prevention and care management, so consumers can avoid care they do not want, like preventable hospital stays and surgeries. (This information is included in HEDIS data.)
- Estimate total costs for care of common chronic conditions, like diabetes, and high-cost situations, like childbirth, so low premiums do not lure people into plans with high cost sharing.
- Create tools to recommend high-value plans based on consumer preference (e.g., doctors they want to keep, plans that manage a specific chronic condition well).

⁹ *Healthcare Spending and Preventive Care in High-Deductible and Consumer-Directed Health Plans*, Buntin et al, American Journal of Managed Care, March 2011.

¹⁰ *Nearly Half of Families In High-Deductible Health Plans Whose Members Have Chronic Conditions Face Substantial Financial Burden*, Galbraith et al, Health Affairs, May 2011.

¹¹ http://www.aarp.org/content/dam/aarp/health/medicare_insurance/2011-07/2011-cro-nin-report-final.pdf

- Recommend high-value plans or automatically enroll people in high-value plans if they do not choose a plan on their own. Default enrollment is a powerful financial incentive for plans to improve their ratings.¹²

Choice Architecture: Marketers have long used choice architecture to influence shoppers, which is why candy bars and other impulse-purchase items are in check-out lanes. School cafeterias are now using choice architecture to promote healthier choices: making it easier to reach fruits and vegetables than French fries and desserts sells more fruits and vegetables, even though fries and desserts are still available. Exchanges that make high-value plans “easier to reach” will also see more shoppers choose high-value plans, even with other options available.

Consumers Union’s Lynn Quincy says Exchange planners should “abandon the image of a careful shopper capable of weighing the myriad costs and benefits of their health insurance options.” Her research on how consumers make health plan choices shows they want value information, but need help finding it.¹³ Exchanges should provide shortcuts that make it easy to compare value and avoid jargon and complex math.

Understanding how people make choices is critical when designing Web portals and report cards to promote value. The standard economic assumption that rational self-interest guides choice is often not the case, says Harvard School of Public Health professor, Katherine Baicker. Consumers instead “have fallible judgment, malleable preferences, make mistakes, and can be myopic or impatient.”¹⁴

Choice architecture considers these realities in order to present information better, to ensure that information is meaningful and to make high-value options an easy choice. This is especially important for Exchanges that let all qualified plans participate. Baicker says presenting too many options can lead to “choice paralysis” that causes people to either give up or make choices based on bias or bad information.

Conclusion: While we are making great strides in using transparency to improve quality and value in health care, we still have a long way to go. We must build on the substantial progress to date, including the recent advances with the standardized Summary of Benefits and Coverage and performance-based bonuses in Medicare Advantage. Transparency in delivery system reforms is crucial to their success; we must be vigilant in using transparency to its greatest potential. We must also work together to ensure that state health insurance Exchanges make the most of their potential for using market forces to promote better value.

Transparency and consumer choice are tools that should be part of a multifaceted strategy that includes payment and delivery system reforms and greater emphasis on patient engagement in their own health and health care.

Of course, success depends on thoughtful implementation, on tailoring to local preferences and on building strong stakeholder consensus for the best approach in each state and for each program. But the value of health care provided in the U.S. will not improve without employing the strategies discussed above.

The CHAIRMAN. Thank you very much, Ms. O’Kane.

And now, Neil Trautwein. We’re very happy that you’re here, sir.

**STATEMENT OF E. NEIL TRAUTWEIN, VICE PRESIDENT AND
EMPLOYEE BENEFITS POLICY COUNSEL, NATIONAL RETAIL
FEDERATION**

Mr. TRAUTWEIN. Thank you, Chairman Rockefeller, Ranking Member Thune, members of the Committee. I appreciate the opportunity to appear before you today.

I’m a Vice President with the National Retail Federation, and I’m pleased to appear on behalf of NRF, which is the voice of all channels of retail distribution.

Retail supports one out of every four jobs in the American economy. We support effective implementation of the Affordable Care

¹²For more information on ratings and decision support, see “Exchange Quality Solutions: Ratings and Decision Support Tools.” <http://www.ncqa.org/LinkClick.aspx?fileticket=RNqddq-GjOnU%3D&tabid=61>

¹³Early Consumer Testing of the Coverage Facts Label: A New Way of Comparing Health Insurance <http://www.consumersunion.org/health.html>

¹⁴<http://www.hsph.harvard.edu/faculty/katherine-baicker/>

Act, despite our continued concerns on the law, itself. We've met, numerous times, with the administration on specific regulatory issues, and we have submitted written comments on key issues. We appreciate the administration's attention to retail concerns. Many retail employees don't fit neatly into full-time or part-time categories, and so, the—certainly, the flexibility issues are important.

Our members are struggling to keep abreast of all the different requirements that are coming up to that 2014 deadline. This is where we really find the hard intersection between the promise of transparency and the burden that employers are carrying, in terms of coming up to speed on compliance on the Affordable Care Act. I fear there's a danger of crowding out employer enthusiasm for movements toward greater focus on quality and cost consciousness in healthcare as a consequence of this. I hope not, because I think the initiatives that NCQA and others have taken in this area, which employers have long been involved in, are very important to driving lower cost, better quality healthcare.

We think it's important that we strengthen these efforts even in the midst of implementation of the ACA. It's not going to be easy. We're seeking to retrain people to seek out the quality options in healthcare. Sometimes less care, or more effective care, is better than more care. And that's a tough lesson for a lot of people to learn. Unfortunately, people are very stubborn in our habits, and we don't change quickly or easily.

Transparency and awareness of better interests, quality and cost, both, are likely the best impetus to changing consumer behavior. Still, it's not easy. We employers have conducted employee briefings, we've brought in outside experts, we've tried to explain the coverage, and we've really gone the extra mile. Many of us weren't sure, on first impression, whether the Summary of Benefit and Coverage provision made sense as an addition to that, and was not just duplicative of the existing Summary Plan Description. Still, the SBC, with coverage examples and the uniform glossary, can be helpful tools for employers and employees toward employee education.

Flexibility in the distribution of the SBC is important. Availability is one issue, comprehension is another issue. How do we entice employees to read the information we provide, we deliver in the SBC, or make available in other contexts? So, transparency is clearly important, but it's not sufficient.

Retailers and other employers are particularly concerned by one element of the SBC, and that is the penalties attached to the SBC for employers who willfully miss delivery of that document. It's very important to get it out to consumers as part of their owner's manual. It's very important to post it where they can get to that when they need it. But, the particular penalties are causing concern in the employer communities. We encourage you to rethink this element of the SBC.

We've received a lot of guidance on the ACA—as Ranking Member Thune indicated, almost 18,000 pages of regulations through this. Two significant regulations just came out last week on the essential health benefits and the insurance market reform. Both will add cost of coverage, perhaps even significantly to coverage. That's a real problem, because people have to be able to afford the cov-

erage we offer. We're working hard to help our members over this communication gap and to figure out how they manage to provide coverage.

In sum, I ask you to continue to encourage greater transparency in healthcare. I think it's a positive element to help drive better-quality and lower-cost care. At the same time, I urge you to be wary and cognizant of the regulatory burden that employers are laboring over as we meet the transition in 2014. Retailers and other employers should be, and can be, powerful advocates for positive change, but the ACA's going to put some pressure on that ability and that willingness to move in that direction. We hope to work with you to help mitigate those effects, and hope to help improve the implementation of the ACA.

Thank you, and I look forward to your questions.

[The prepared statement of Mr. Trautwein follows:]

PREPARED STATEMENT OF E. NEIL TRAUTWEIN, VICE PRESIDENT AND EMPLOYEE
BENEFITS POLICY COUNSEL, NATIONAL RETAIL FEDERATION

Chairman Rockefeller, Ranking Member Thune and honored members of the Committee, I thank you for the opportunity to appear before you today and to share our views regarding the Affordable Care Act (ACA), the need for greater transparency and the ACA's Summary of Benefits and Coverage (SBC), Coverage Examples and Uniform Glossary provisions. My name is Neil Trautwein and I am a vice president and Employee Benefits Policy Counsel with the National Retail Federation (NRF).

As the world's largest retail trade association and the voice of retail worldwide, NRF represents retailers of all types and sizes, including chain restaurants and industry partners, from the United States and more than 45 countries abroad. Retailers operate more than 3.6 million U.S. establishments that support one in four U.S. jobs—42 million working Americans. Contributing \$2.5 trillion to annual GDP, retail is a daily barometer for the Nation's economy. NRF's *Retail Means Jobs* campaign emphasizes the economic importance of retail and encourages policymakers to support a *Jobs, Innovation and Consumer Value Agenda* aimed at boosting economic growth and job creation. www.nrf.com

NRF supports effective implementation of the Affordable Care Act, despite our continued concerns about the law itself. We remain greatly worried by the fast-approaching deadlines for key issues affecting coverage in every market, especially in light of the steady torrent of regulations from the Administration. Our nation cannot afford for the ACA to stumble out of the starting gate. We fear that as time diminishes between now and January 2014, a cascade of last minute regulations will create confusion and thus could encourage more employers to back out of coverage.

NRF and ACA Implementation

NRF has been closely engaged in the regulatory process ever since the ACA was signed into law. We have met numerous times with regulators and have submitted written comments on key concerns. We have assisted in submitting joint coalition comments as well. We have not been litigants against the ACA and also did not submit amicus comments in the ACA case before the Supreme Court.

We credit the regulatory agencies¹ for working hard and fairly cooperatively to implement the ACA, a difficult task by any measure. The Administration has been properly solicitous of the greater retail industry, both because of our industry's important role in the economy as well as the nature of retail employment. Many retail and restaurant employees do not fit neatly into full and part-time categories and compliance with the unprecedented levels of change under the ACA will be particularly challenging.

This is where we find the hard intersection between the promise of transparency to help employers and consumers find better value in health care and coverage and employers straining to their new responsibilities under the ACA, some beginning as soon as June this year. There is the danger of crowding out employer enthusiasm for driving better quality and lower cost health care through initiatives from the Pacific Business Group on Health, along with my fellow panelist from NCQA and

¹Departments of Health and Human Services, Labor and Treasury.

many others. NRF strongly supports these initiatives. It is important in our view to preserve and strengthen these employer-led reform efforts, even as implementation of the ACA continues.

Changing Behavior

Change at any level is difficult. We are attempting to retrain people to seek the better quality health care options. Sometimes, less (but more effective) care is better than more care. I recall the frustration of a former member of mine in a different association (Francois de Brantes, then of GE, now of Bridges to Excellence) saying that he could place neon exit signs leading to better quality health care providers, but most employees would rather stick with their old, inferior quality and more expensive providers instead.

We humans are stubborn in our habits, good or bad. Transparency and awareness of better interest—quality and cost both—is likely the best tool toward building better consumers of health care and coverage.

Summary of Benefits and Coverage

Health benefits are the biggest component (next to wages) in employee compensation. Employers have struggled mightily to help employees understand and get the best value from their benefits. Distribution of Summary Plan Description (SPD) documents are just the beginning. Employers have conducted countless employee briefings (both by company staff and outside experts, such as agents and brokers) among other efforts to help educate eligible employees. Many employers have built web-based resources to help guide employees through benefits issues.

The new Summary of Benefits and Coverage (SBC) requirement and Uniform Glossary are the latest manifestation of this employer objective: to help employees and dependents understand the content and extent of their coverage options. Employers were not entirely sure that the SBC was necessary and not just duplicative of the SPD. Still, the SBC with coverage examples and Uniform Glossary can be helpful tools for employers toward employee education.

Flexibility in distribution of the SBC is helpful. The ability to post electronically and to e-mail SBC's (subject to notice and on-demand availability of paper copies) is efficient. Nevertheless, availability is one issue and comprehension is entirely another. How do we entice or compel employees and dependents to read and understand their benefits?

Some benefit designs seek to use financial interest—our wallets—to help lead our brains to better health care decisions. Results are encouraging but inconclusive. Ultimately though, we may need to look to our children and grandchildren to take this closer to heart and better interest. That awareness just might be forged in a generational crucible built as a consequence of the graying of America. It will not be a pain free process, unfortunately.

Retailers and other employers are particularly concerned by one element of unwarranted SBC compulsion: employer penalties for willful failure to distribute SBCs. These penalties are expensive—at \$1,000 per willful failure with daily penalties of \$100—and when added to myriad other potential penalties and fees under the ACA, could tend to discourage employers from offering coverage. We recommend that this Committee and the Congress rethink this portion of the SBC requirement.

In addition, we are concerned by the SBC requirement that SBC be made linguistically appropriate for populations where 10 percent or more are literate in a non-English language. This is an expansion of an old SPD requirement and in practice employers have adapted where necessary, for example to hold Spanish language briefings. Still, we fear that the new SBC requirements will add to carrier cost and thus to coverage cost, too.

Affordable Care Act and Employers

Change is coming to employer-sponsored health plans at a torrential pace. In testimony² last year to the House Ways and Means Subcommittee on Health, I warned that definitive regulatory guidance was needed at least by the first quarter of 2013. The regulatory pace has definitely picked up after November 2012.

We have received a lot of regulatory guidance—some 18,000 pages of regulations by some estimates—with two significant regulations on essential health benefits and health insurance market reform coming out just last week. Both the EHB and market reform provisions (especially the compression of age bands) very likely will add to coverage costs.

NRF has worked hard to help our members understand what their options and future responsibilities will be. I provided both majority and minority staff with a

²September 12, 2012

copy of the slides from a recent NRF webinar presentation on ACA compliance. Another is planned for March and likely will continue throughout the year. I spend a lot of time speaking to diverse retail and other employer audiences as well. The learning curve among retailers and other employers is steep and still growing.

NRF, Allied Coalitions and the Affordable Care Act

NRF has actively encouraged the fair and effective implementation of the ACA, despite our continued opposition to the law itself. We see no inconsistency between the two positions; we owe it to our members to help make the law as workable as possible so long as it remains the law of this land. We stand ready to assist any effort to improve upon implementation of the ACA.

We are engaged in a number of allied coalition efforts on ACA implementation. For example, NRF chairs the Essential Health Benefits Coalition³ (EHBC) and participates in the leadership of the Coalition for Choice and Competition⁴ (CCC) and Employers for Flexibility in Health Care (EFHC). The number of coalitions addressing aspects of ACA implementation has grown so much as to require a degree of coordination between them. NRF established and chairs the Employers' Health Care Clearinghouse, which meets on a monthly basis to do just that.

These coalitions are deeply substantive and deal with specific ACA implementation concerns. They also have served a useful role in developing and coordinating views and comments among allied employer interests.

Conclusion

Again, NRF greatly appreciates the opportunity to appear before you today. In sum, we urge this Committee and Congress to continue to encourage transparency in health care to help drive better quality and lower cost care and coverage.

At the same time, we urge you to guard against the pace of ACA implementation and the consequent potential to drive employers away from providing coverage. Retailers and other employers can and should be powerful advocates for positive change. But, in most cases, health care and health benefits are not our stock in trade or business. It is in our best interest to keep our employees healthy and at work, but not at any cost. The ACA will—at a minimum—pressure our ability to continue to provide coverage and help drive positive change.

We hope to work with you to help mitigate these effects. NRF stands ready to help the Administration and Congress make the ACA more workable, so long as it remains the law of this land.

The CHAIRMAN. Thank you very much, sir.

It seems to me that, in preparing for this, I read that—and you were concerned, Ms. Quincy—that we have to get to 170 million people. And we're not. And I think that's partly because it's still new, and, you know, all this kind of stuff. But, my impression was that, if you took the cost, which you referred to, of doing all of this transparency, et cetera, it is large and burdensome—I think that it came out that it was about 50 cents a person per year. And that actually does add up to \$70 million, or whatever it is. But, in terms of the individual, if that's what it costs, it would seem to me that the tradeoff for knowing more about what you're getting—I mean, I really get an amazing feeling, just looking at this thing.

Senator Thune, I've been doing this.

And you—you know, it just—it's just so sensible. You look down at—well, having a baby. And you get the sample care costs. Now, I assume—and it gives—it says, the amount owed to providers is going to be 7-and-a-half-thousand dollars; plan pays 5,000-and-a-half, patient pays 2,000. But, it gets all—radiology, prescriptions—it gets all those things. And then it says what the patient has to pay—and it says “deductibles,” gives the amount; “copays,” gives the amount; “coinsurance,” and gives the amount. What it does not say, and what I want to bring up in a question, is—and I don't

³ www.ehbcoalition.org

⁴ www.choiceandcompetitioncoalition.org

know why it's left out—is that we don't include premiums. And it seems to me that premiums ought to be a part of the SBC. It's—I think it's only fair. And so, therefore, it doesn't show up here, and, therefore, it's a—that's, I think, one area where we could be—we could improve.

But, I understand your point, and I—I had a—spent an hour and a half yesterday, somebody, in HHS, who had just put out 600 pages of new rules and regulations for something, and I was just flying around the ceiling, in anger. And, of course, there was a strong defense on her side, which she felt was OK, and I just didn't. So, I mean, I think that's constantly a problem.

I think it's going to—I think it's going to be a problem, too, as we settle into—I mean, in effect, it was last year—October 31, I think—when the Affordable Care Act actually went into business, became operational. But, in fact, it isn't, and it's really 2014.

Now, there's a lot that's already been done, but it's when you—when you get the exchanges, and getting them set up, and having the states figure out what they're going to do about that. And some things—again, medical loss ratio and, you know, preexisting conditions—those things are already in play and in effect. But, I suspect that there will be a period, probably of a decade or so, where we will be adjusting this bill according to, you know, common sense and reasonableness, while still driving toward the purpose of transparency.

I don't have much time left.

The—I really like the idea, I have to say, of real-life examples, because I think if somebody picks this up, and they look at having a baby or diabetes 2, et cetera, and they really get a sense of what it is—and I mentioned, in my opening statement, breast cancer. And the breast cancer was excluded as part of this list by, oddly enough, IRS, the Department of the Treasury, and Department of Labor. I have absolutely no idea of how they got to do that. Do any of you? Because, to me, breast cancer is something that has to be faced by so many people that it would really be good, as a real-life experience, in the cost of care. And—

Yes, ma'am.

Ms. O'KANE. Well, I'm speculating, but breast cancer, as you're probably aware, it depends on how serious the breast cancer is, what the costs are going to be. So, it's probably hard to have sort of a generic example of what it would cost. That's—that would just be my speculation. You know, so if you're—if you were—had your breast cancer on a mammogram at a very early stage, there would be a lumpectomy, there might not be any chemo, there might not be any radiation. And that would be a—sort of a low-cost event. Whereas, if it were something more advanced, there would be much higher costs of treatments, and so forth, so—

The CHAIRMAN. Well, it would be my assumption—and then I'll go right to you, Ms. Quincy—that this would be based upon the average cost. This wouldn't be individual breast cancer, but writ large, and then cut right across the middle.

Ms. O'KANE. I just think, because there's a big range of variation that feeds into that average, it might not be as useful as having a baby. I'm just—

The CHAIRMAN. Yes.

Ms. O'KANE.—thinking out loud, here——

The CHAIRMAN. Yes, ma'am.

Ms. QUINCY. We are so fortunate, with this particular provision of the law, because we have so much evidence. We did test a breast cancer example when we were testing the form. It was for a year's treatment that totaled to about \$100,000. And two things I might mention. One, it's—this was the most persuasive example, because that's where it really reminded people that, "Oh, a very expensive and unexpected medical event could happen to me." Even the men, who can't get breast cancer. Still, it reminded them why they need to go out and buy health insurance. And, frankly, I said to the health plans, "This is—should be your marketing tool. You know, drum up some business with these examples."

And it doesn't matter if it is your exact breast cancer experience. What matters is, you can compare it across health plans, because it was calculated in the same way—just like EPA's miles-per-gallon sticker on cars. That's what is important, at the end of the day. And hope that an expensive example, like breast cancer, will be brought back. So, thank you for mentioning it.

The CHAIRMAN. Thank you. My time is up.

The Ranking Member, Senator Thune.

Senator THUNE. Mr. Chairman, thank you.

And thank you all for sharing your thoughts and your insights. I very much appreciate that.

I'd like to direct this question, if I might, to Ms. Quincy. And it has to do with the agency's final rule, which was jointly issued by HHS, Labor, and Treasury, which does not require that the SBC include premium disclosures or additional facts that may affect premium rates. The only way that an issuer can comply with other sections of Federal law and premium rate changes is to issue disclosures on multiple forms.

Now, we've heard, today, that multiple disclosures can add to consumer confusion. So, to your knowledge, as a consumer representative with the National Association of Insurance Commissioners, tell me about NAIC and any efforts they made to consolidate these disclosure requirements. And is this a concern that the agency should revisit as they work to improve the SBC disclosure process?

Ms. QUINCY. Thank you very much for that question.

When the NAIC was working to develop the form, it included a line—the very first line on page 1 was for the premium, because that's the natural thing that you would want to know, in addition to how much coverage you're getting, if you're trying to compare health plans. And that's the intent of this form.

So, we did test a premium line on there. And that was, as you can imagine, very well received. The NAIC had extensive discussions about how to accommodate the fact that, when there is underwriting, you might not actually know the final premium, and they provided, to HHS, a set of rules for how to accommodate those circumstances.

Just as an example: on *Healthcare.gov*, you don't see your specific premium, you see a standard premium rate. That's one of the ways you could fill in that line.

I think this would be an excellent area for some statutory revision, because I think consumers would love to see premium on that form.

And let me know if that didn't answer your question.

Senator THUNE. How do you take into consideration regional differences, in the disclosure process? Getting treated in someplace like Sioux Falls, South Dakota, is very different than getting treated in New York City. I hope implementation of this provision doesn't have the unintended effect of confusing consumers. Can you explain how regional differences in the cost of care are going to be addressed?

Ms. QUINCY. Absolutely. The—first of all, I—for what it's worth, I have no concerns that it would confuse consumers. You already have regional differences in the coverage provisions; you know, so you already are designing an SBC form for the exact product that's been licensed—been licensed in South Dakota, as opposed to—I forgot, was New York the other state?—as opposed to the second State. So, you're already preparing a form that reflects the product that you had approved by your local State insurance department.

But, that—your question is still a valid one, because we know, in 2014 and forward, there are still some remaining premium rating factors, such as geography and age. And I think the question is, How do you accommodate them? And I think there are a number of things that can be done:

One, you can put the premium line back on the form, label it as "Premium," and leave it blank, to be filled in. If—let's say a consumer's working with a broker. Sooner or later, a premium will be calculated for that person, and it can be written on the form so that they can take it home and compare it to other plans.

There's a number—this is the exact question the NAIC dealt with, and I would be happy to send to the Committee their proposal for how that would be addressed, if—rather than go on and on—if—would that be helpful?

Senator THUNE. That'd be fine, yes, thank you.

Mr. Trautwein, in your testimony today, you mentioned your concern with the pace of implementation of provisions in the Affordable Care Act. And specifically, you state your concern that last-minute regulations, on top of penalties and regulatory burden of existing ACA regulations, might cause of your members to, and I quote, "back out of coverage." This a very troubling suggestion. Provisions, such as the SBC, are intended to increase choice and competition in the healthcare insurance industry, with insuring benefits to the consumer. But the way in which the statute and other mandates fund the law, or implement it, could drive employers away from offering health benefits altogether. It would seem that the opposite could be true. I wonder if you could expand on that statement that you made in your remarks.

Mr. TRAUTWEIN. Thank you, Senator.

There is a lot of frustration out there in the employer community as they look forward across the horizon to 2014. I'm spending a lot of time on Webinar presentations and other methods of explaining this to them.

When they look at the combination of different factors—they look at the size limitations, the redefinition of the "full-time employee,"

some of these concerns—then it gets to be—there’s—there starts to be some focus on, “Well, is it—can I look to offload my employees onto the exchange? Is it mathematically cheaper? Does it make sense, in today’s economy, to do that? Or do I continue to soldier through and continue to offer coverage?”

So, what I particularly fear—one of the things employers hate more than anything is having multiple requirements put on them at once so they’re trying to do a bunch of different things at the same time. That’s what the quick horizon to 2014 threatens—I fear, threatens—because we don’t want to undercut employer-sponsored coverage, but I think that could be the practical effect.

Senator THUNE. I see my time has expired, Mr. Chairman. Thank you.

The CHAIRMAN. All right.

Senator Pryor.

**STATEMENT OF HON. MARK PRYOR,
U.S. SENATOR FROM ARKANSAS**

Senator PRYOR. Thank you, Mr. Chairman.

And I’d like to start with you, Ms. Quincy, if I could. One of the amendments that I offered, and it was adopted into the ACA, was an amendment on a customer satisfaction survey. And I’m assuming, you know, it’ll take a little time, maybe a year or so, before the exchange is running, and all that, before the surveys really mean a lot. But, do you think that information will be helpful to consumers as they are weighing their various options in the exchange?

Ms. QUINCY. Yes, I do. And just so I give you a responsive answer, are you talking about satisfaction with the exchange or with health plans?

Senator PRYOR. Well—

Ms. QUINCY. Or both?

Senator PRYOR. What—I was thinking about with the health plan.

Ms. QUINCY. OK. In the testing and discussions we’ve had with consumers, they’re very interested in what other people, like themselves, think of a given health plan, a given doctor, a given hospital. This is a primary piece of information that they’re interested in. And I think that, referring back to Peggy’s testimony, if we can do the survey and convey the results in a way, to consumers, so that it’s usable and they feel this reflects people who are just like them, they would find it very, very valuable.

Senator PRYOR. Right.

Mr. Livermore—oh, yes, ma’am. Ms. O’Kane.

Ms. O’KANE. Just on that point. We accredit health plans, and every health plan has to submit results of their consumer satisfaction survey, which is then used to benchmark and compare, and it leads into the rating that the plan gets. And then we take the data, and we do ratings with Consumer Reports.

Senator PRYOR. Oh, good. Seems to me that it’s—that’s a good way to go. It, you know, lets consumers get a read of, you know, how the plan is actually working in the real world.

Mr. Livermore, let me ask you a question. And it’s really a concern I have. And that is—my concern would be that there will be

a lot of people, especially in the early days of this, that aren't really familiar with shopping for their own healthcare plan, and they may just look at the premium, and then nothing really beyond that. You know, they may not look at all the copays and all the other—what folks who know about it wouldn't consider “hidden expenses,” but, if you're not careful, they might be considered hidden expenses. So, do you share that concern? And, kind of, what are our best practices that we can implement that would make sure that that's not a big problem?

Mr. LIVERMORE. Yes, I absolutely—thank you for the question—I absolutely do share that concern. I think that it really points to the need for evidenced-based models and testing of how the label actually works. In the abstract, as experts, you can look at it and say, “This is all perfectly clear; it's obvious,” but that doesn't mean that that's how consumers are responding to it. So, I think that that really, I see, is the key—a key feature for improving and continually, you know, expanding this—the use of this label, is that ongoing testing and procedure.

Now, there are certain things that you can do to make sure you're using best practices. Right? So, information that you present first is going to have a large cognitive impact, you know, on someone that's interacting with this document. So, you know, you can use color, simplify language, not overwhelm the consumers with too much information, so you have the most salient information. Coverage examples are an important—can be an important counterbalancing influence. So, all of these are features. But, at the end of the day, testing is what we ultimately—and improving, based on that information—is ultimately how we answer that concern.

Senator PRYOR. One of the things that you mentioned in your testimony is “low health literacy” in the U.S. And apparently there's a pretty substantial cost connected with the illiteracy, I guess you can say, of—in healthcare, for Americans. So, what's the low hanging fruit there? What can we do to make the American public more literate when it comes to choosing healthcare?

Mr. LIVERMORE. Well, I think that, in terms of steps forward, expanding the coverage examples are a very useful low hanging fruit; in particular, a high-impact event, because that's something that consumers are not going to be familiar with, by its very nature. These are low-probability events, and then they're extremely high-impact. And, you know, a consumer making the decision is not familiar with that. They might not even have family members that are—where they can utilize that experience. So, I think that that is a simple thing that can be done, and it's low hanging for us.

Senator PRYOR. Yes, ma'am.

Ms. O'KANE. We heard a presentation from somebody that was experimenting with how to present the information to consumers, and they found that just giving a little tutorial up front about, you know, what to think about before you get into it was helpful. And then, there are choice tools, as well, that help you calculate what your total expenditure for the year might be. Those have been used.

So, I think that, actually, the experience of shopping in exchanges can be something that will improve people's health literacy just in time, if we do it the right way.

Senator PRYOR. Thank you.
 Thank you, Mr. Chairman.
 The CHAIRMAN. Thank you, Senator Pryor.
 Senator Cruz. And welcome.

**STATEMENT OF HON. TED CRUZ,
 U.S. SENATOR FROM TEXAS**

Senator CRUZ. Thank you, Mr. Chairman. And it is a pleasure to be at that—the first hearing that I’ve had the opportunity to serve on this committee.

Of all of the economic data that swirl about, the one I find most troubling is 0.8 percent, which is what our economic growth has been, each of the last 4 years. It seems to me, if we’re going to make progress, in terms of restoring our economic strength, if we’re going to make progress, in terms of seeing the 23 million people struggling to find work, getting back to work, we’ve got to restore economic growth, we’ve got to get back to historic levels of growths—3, 4, 5 percent—and not sub 1 percent economic growth.

And so, Mr. Trautwein, I would like to ask you a question about the impact of the President’s healthcare law on small businesses, in particular. There have been a number of estimates that small businesses typically produce two-thirds of all new jobs. And the House Energy—Commerce Committee has recently estimated the compliance cost of Obamacare has exceeded 127 million man hours. And the question I’d like to ask is if you could share your experience, and the experience of your members, in terms of the impact of compliance costs, and how that is affecting their ability to survive in this challenging economic times, and their ability to create and maintain jobs.

Mr. TRAUTWEIN. Thank you for the question, Senator.

The small business is struggling to understand their responsibilities under the new law. They’re coping with questions about how you’re defining “full-time employee.” How many employees can you have before you’re over the top? Do you count partial employees to get up to that 50 limit of full-time-equivalent employees? So, there are a lot of issues, at present.

We do know that it’s had an effect of discouraging growth at companies near that threshold, and it may have an effect—in fact, somebody called them the “29ers”—of redefining many employees below that threshold. And that could be an issue, as well.

Counterposed against that are the small business tax credit, limited or—and complicated though it be. And there are also subsidies potentially available, by income, in the exchange, though those ramp out pretty quickly.

So, it’s—so, to sum, there’s a lot of frustration with the complexity of the Affordable Care Act. It may be having an effect on job growth, particularly in small business. And they’re very nervous about this transition.

Senator CRUZ. What has been the experience of your members, to date, in terms of small businesses dropping coverage altogether? Have you seen that as a significant pattern since the passage of this law?

Mr. TRAUTWEIN. It’s been more of a episodic adventure, Senator—or feature. From what I can tell, the—even though we’re in

2013, as of June, counting back for the look-back period, really that the penalties are not effective until 2014, forward. So, I've encouraged many employers, some who are grandfathered status and some who are not, to ride it out, for now, and to keep coverage intact. But, there are a lot—as I mentioned, there's a lot of frustration, a lot of—particularly in small business—who say, "My business is X, not healthcare." And so, there's a lot of frustration there.

Senator CRUZ. My last question concerns the cost of coverage; and, in particular, the cost for those struggling to climb the economic ladder—young people coming out of school, getting their first jobs.

A recent study by the American Academy of Actuaries found that insurance premiums in the individual insurance market will increase, on average, by 10 to 20 percent, and approximately 4 million uninsured individuals age 21 to 29, or roughly 36 percent of those currently uninsured, can expect to pay more out of pocket for single coverage than they otherwise would have.

Has that been the experience you've been seeing in the market? That the impact has been coverage costs increasing and impacting, in particular, those struggling to climb the economic ladder?

Mr. TRAUTWEIN. There's been some, but a limited, increase already reflected in the market. One of the things I worry about is the regulation released on Friday on health insurance market reform, and the compression of age rating bands from, commonly, 5-to-1 to 3-to-1. That's going to increase premiums for younger, healthier employees, the kind that you want in your group, three times or more. And that could have an effect on overall group coverage.

We advocate—and the administration said they lacked authority to do this—but, a more effective way might be to allow the States to come up a plan—with a plan, maybe 5-year plan, to get to that target amount. But, hopefully that's something that the Congress will come back to, because that potential rate shock could be an issue—substantial issue in 2014 and beyond.

Senator CRUZ. Thank you very much, Mr. Trautwein. And thank you, to all of the witnesses.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator McCaskill.

STATEMENT OF HON. CLAIRE McCASKILL, U.S. SENATOR FROM MISSOURI

Senator McCASKILL. Thank you.

I know that there are competing arguments on the rate-shock argument, also. I mean, we have a huge number of our young people that are now on parents' policies until they're 26 years old. Obviously, if this reform went away, they would be back on the market. That's quite a rate shock.

And also, the catastrophic—if any of you want to speak to the catastrophic coverage that will be available to young people, that currently has not been readily to consumers, and what impact you think that might have on this reputed rate shock that's going to occur for young people.

Ms. Quincy?

Ms. QUINCY. I'd be happy to speak very briefly. I mean, excellent comments. But, the Wyman study and the Society of Actuaries study—there are some other studies out there that show that this rate shock concerns are going to be mitigated by the availability of subsidies to help afford coverage and, as you mentioned, by the availability of a catastrophic plan. And this catastrophic plan is essentially going to be full of young people. They're their own pool; they're not pooled with others. So, this is going to mitigate, greatly, the impact of the rate shock, because—some of the other studies didn't take that into account; like, I don't think the Wyman study did.

I'd be very happy to send over to this committee a study by the Kaiser Family Foundation and another one by the Urban Institute showing that maybe we don't need to be quite as worried as some have suggested.

Ms. QUINCY. And I'm not trying to say that there will not be some people for whom their rates go up. Sometimes it's because their coverage was so much better. But, I don't think the problem is necessarily as great as some of the reports show.

Senator McCASKILL. Thank you.

I have also read the *Time* magazine article, and I will tell you, I think that there is a rebuttal that is—needs to be put out there on some of the things that are in that article. You know, points were well made in the article, but there is another view on some of these issues around the not-for-profits, especially those that are serving the most difficult populations, in terms of underinsured and uninsured. And I want to make sure that the policy discussions around this are fair and measured.

Now, one thing that was in that article that is fascinating is the charge master. The charge master, obviously, came about for a purely commercial reason, and that was: insurance companies wanted to go to employers and say, "We're getting you a big discount." So, in order for them to get a big discount, the charge master had to increase what the charge was for the service.

So, let's say an MRI was going to be \$400. That's what the costs really were going to be. And the insurance company said to the hospital, "Well, we really need to tell our employers that we're getting you a better price, so we need to say we got you a discount," and they said, "OK, we'll have a charge master say the charge was \$800, and you're getting a 50-percent discount." So, it was all illusory. It was all kind of made up. And—

But, the point that the article wasn't very good about pointing out is that that is really only being used for outliers now, because the vast majority of the charges now are, in fact, for procedures. There is a set amount for procedures.

And if any of you would comment on what we need to do, in the transparency world, to get companies out of the habit of creating discounts that totally jack around with the ability of a consumer to ever figure out what something really costs. And, you know, maybe we need to look at this issue of—I think they've outlived their usefulness, charge masters; I don't think they are being used as often as they were when this first began as a practice. And I would like any of you who feel knowledgeable about this subject to speak to that.

Ms. O'KANE. I don't think I'm an expert on this, but I think—your point is really well taken. It's really hard to figure out. Right? And different payers pay different amounts, which have nothing to do with the underlying value of the product. We have markets where there's so much consolidation in the provider sector that they kind of name their prices, and that goes right through to the consumer.

So, I think that there is a big issue around price. There's a big issue around what we do, as well. But, you know, the issues that he identified in the article, I think really do call for some public-policy response. And, you know, there's a range of possible responses, like you could set prices. That seems sort of—kind of politically unlikely, to me. But, certainly, I think that the current—

Senator MCCASKILL. We have set prices for Medicare and—

Ms. O'KANE. Yes, exactly.

Senator MCCASKILL.—Medicaid, right?

Ms. O'KANE. Exactly.

Senator MCCASKILL. I mean, that's what they've done—

Ms. O'KANE. Yes. But, then—

Senator MCCASKILL.—is set prices.

Ms. O'KANE. But, then we find that providers then shift those costs over to the private sector, driving up the cost of private health insurance. And—

Senator MCCASKILL. Yes. I mean, I believe that if you look at it—if you back up, you've got a population that's paying 70 percent of what the costs actually are, and another population that's paying 130 percent of what the costs actually are.

Ms. O'KANE. Right.

Senator MCCASKILL. Well, that's certainly not fair to the people who are paying 130.

Ms. O'KANE. Right.

Senator MCCASKILL. But, it's a great value for the government, that's getting the 70.

Ms. O'KANE. Yes.

Senator MCCASKILL. And so, how we figure that out—and people who are in large companies that have lots of employees are getting the 70.

Ms. O'KANE. Well, no, actually, they're—they're paying higher—they're paying higher rates, because they're buying—I mean, they're self-insured, but they're only able to get the rates that their intermediaries are able to negotiate, which are not as low as Medicare rates. They do better, though, than the small businesses—

Senator MCCASKILL. Right.

Ms. O'KANE.—which are really at the end of the—

Senator MCCASKILL. They're not at the 130, but they're not at the 70.

Ms. O'KANE. Right.

Senator MCCASKILL. They're somewhere in between.

Ms. O'KANE. Right. Right. But, I think it's a mess, and it's certainly—you can't have a market that actually works, when you have this kind of disinformation out there.

Senator MCCASKILL. Well, I'm a big—I know my time is up, and I appreciate you being here—I'm a big believer that one of the most important things we have to do in the healthcare area is unleash

the American consumer. I mean, we are good shoppers. We know how to shop. I mean, you give me enough coupons, and I'll drive 15 extra minutes and get that value.

You know, look at Groupon. I mean, look at the successes that we've had by—you know, I mean, look at Wal-Mart, for gosh sakes. So, I think we've got to figure out a way that the American consumer feels entitled to consumer information about buying healthcare. Right now, they just see it as something they either get for free or they don't have it and somebody else is going to pay for it—

Ms. O'KANE. Right.

Senator McCASKILL.—instead of really feeling invested in a consumer-based decision. And a lot of that is just around the area of can they get enough information to become a good consumer?

So, I think this is a great hearing, Mr. Chairman, and I'll look forward to hundreds of other great hearings, with—under your leadership, over the next several years.

The CHAIRMAN. Hundreds.

Senator McCASKILL. Hundreds.

[Laughter.]

The CHAIRMAN. Senator Schatz.

**STATEMENT OF HON. BRIAN SCHATZ,
U.S. SENATOR FROM HAWAII**

Senator SCHATZ. Thank you, Mr. Chairman. And thank you for holding a hearing on this—OK, excuse me. Here we go.

Thank you, Mr. Chairman, and thank you for holding a hearing on this important topic.

I want to thank the witnesses for being here.

And I share your view, Mr. Chairman, that greater transparency in health insurance policies is needed for consumers to better make choices.

I have a couple of questions that have to do with the process of making choices. Mr. Livermore, in particular.

According to Census data, approximately 25 million adults in the United States don't speak English well. And in Hawaii, limited-English-proficiency individuals account for almost 12 percent of the State's population, including my mother- and father-in-law. Health insurance companies have to communicate effectively with this percentage of the population in order for this enterprise to work. So, what steps can be taken to make sure that those folks who are having difficulty with English can get access to plain and simple information so they can make the right choices?

Mr. LIVERMORE. Yes. Well, thank you very much for that question.

I think there are two elements to this. One is making sure that we're providing the information in the languages that people speak and they can actually understand, but the second part has to do with making sure that folks are aware, within these communities, that this information exists and is accessible to them. So, there's the provision, but there's also, kind of, outreach—there's an outreach element to that. And, actually, Ms. Quincy mentioned, earlier, that an unfortunately low percentage of people are aware that the SBC exists. I don't have data on this; she may. But, my—I sus-

pect that, within particular linguistic communities, that number is even worse. Right? And so, we have to think about how to do that outreach.

That would be my primary recommendation, would be, not just the provision of information, but making sure that folks are aware that the information is out there and accessible.

Senator SCHATZ. Ms. Quincy?

Ms. QUINCY. An excellent question. I think—a couple of additional observations. One, the fact, with the SBC, that we're talking about a standard form helps, because even if you struggle a little bit with—maybe it's—hasn't been translated into your language, you can learn, because it's always standard, where the given information is. Somebody could help you with that. So, we're a little bit ahead of the game by having a standard form.

I would pile onto what Mr. Livermore said by saying, in addition to translating these documents, we need to test them with people who speak that language, because you never know what cultural references may not come through.

I did a study, years ago, and they were trying to explain what “radiology” was to someone who didn't speak English, and they said, “It's like a fire going through your body,” and that did not go over well.

So, there you go.

Senator SCHATZ. Thank you very much. And I appreciate the cultural-competency layer to this, because it's not just language translation, but it's understanding the dialects within ethnic communities, and just understanding that there may be different attitudes toward healthcare and the provision of health services, that all needs to be baked into this process.

I have another question about accessing this information. You know, the first draft of SBC is in print format. And, as you know, many low-income individuals, and individuals at all income levels, are going to be accessing this decisionmaking process via the Internet. So, I'd like you to talk a little bit about the usability thought process, not just for the Internet, generally, but also the potential differences between desktop and laptop computers and PDAs. Increasingly, especially in low-income communities, because they don't want to pay the monthly for their Wi-Fi or their Ethernet connection, the only way they're going to get information such as this is via an iPhone or some other Smart phone.

So, what thought process is being undertaken to making sure that this information, which is extraordinarily complicated, gets distilled into this little 2x4 screen?

Mr. LIVERMORE. Just as an initial take, I think that distilling information is, at some level, the first cut—getting it down into, you know, the compact information you want to—that you want to communicate to consumers, and then making sure that it's available on a wide range of platforms. All right? So, this is kind of a two-step process, and I think we're in the midst of that second stage of making sure that it's, kind of, platform availability, in addition to the information.

Ms. QUINCY. If I can pile on—my favorite occupation—I think—I may just not be creative enough, but I can't conceive of how you would actually get, like, the full content, that you would expect to

see, for example, at an exchange, on a little phone. But, I think that it could play a very useful role, in terms of raising awareness and providing preliminary information that then links people to help. You know, it links them back to a full Website, it links them to live assistance. And that's what I see as the role for this very small screen.

Senator SCHATZ. Right. I—and I agree. I actually think the Web-based and the PDA-based decisionmaking tools ought to be used as an interactive decisionmaking tool, because, you're right, you can't load all the information onto one or several pages. But, in a way, it could be even more useful, because you could take someone through their decisionmaking process in a way that is step-by-step, and, therefore, more user-friendly, rather than giving them a document and asking them to digest it.

Thank you.

Thank you, Mr. Chair.

The CHAIRMAN. Thank you very much, Senator.

I'd like to make a comment or two, I guess, emanating out of some of the things that Senator Cruz said, and also that you have said, Mr. Trautwein.

And I think we've all been through this before. You get the situation where—Senator Thune and I are working on this—that—called cybersecurity, when it's the greatest national security threat, it is greatly in advance of terrorism of 11—you know, 9/11s, et cetera, but somehow it doesn't get through to the American people, so we're trying to do something about it. And then you get a deluge from the Chamber of Commerce, the—by their paid lobbyists, here in Washington, which crushes any attempt to get any amendments passed. We couldn't get anything done.

So, I wrote a letter to 500 of the top, you know, individual companies in America, and the majority of them said, "No, we're not protected. We don't know what to do. We need help." These are big companies. "And we don't know where to turn."

And then, the Chamber of Commerce turned on them—you know, the GEs of this world, or whatever—and said, "Well, they don't really know what they're talking about."

And I have, a little bit, this feeling on this healthcare discussion, that this behemoth—I think you have to start with the knowledge of what an absolute disaster of cost, waste, fraud, and abuse, of duplication, that our present healthcare system is. Let's start with what we've got.

I still remember Richard Darman. Do you remember Richard Darman? Yes. He was head of OMB under Ronald Reagan, and he came and testified for the Finance Committee, and he went into sort of a seclusion for a week before he testified, and he appeared, sheet white, not because he wasn't feeling well, but because of what he'd learned. And he basically told us—this was, what, 15–20 years ago—that healthcare was going to decimate the American economy; it was just going to eat it up; there would be no money left for even a single Tootsie Roll. And I always remember that, because the healthcare system was in a mess then; it's in a greater mess now, while, at the same time, not providing insurance for a whole lot of people who really need it.

So, when people start talking to me about, “This is just going to be the downfall”—I was very intimately involved with the writing of this bill, and there certainly are areas where we can make improvements, but, you know, where—you were talking about small business. Ninety-six percent of the businesses in this country with more than 50 employees already offer health insurance to their employees. And RAND, the Urban Institute, the CBO, and Mercer, which is a county in West Virginia—and otherwise, I guess, a research firm—have found that the vast majority of those employers will continue to offer their employees health insurance in 2014. In other words, they listened to all of these comments about—the end-of-the-world comments, and—but then they look at what they have, and they said, “My gosh, it can’t be worse than what we’ve got.” Plus, they aren’t providing health insurance to the people that they would like to.

Then you look at the law, at the Act. Starting in 2014, businesses with fewer than 50 employees will have a new option available to them. To all of them. And it’s called the state exchanges. So, anybody can go get health insurance; again, using these new slimmed-down reading materials and information. And then, if you’re—if you have fewer than 25 employees, you already get a—you already get a deduction—a credit, I guess it is, isn’t it?—for 30 percent of the cost of—the government helps, in the bill, already law, with the—with 30 percent of the cost of providing health insurance. And in 2014, that goes to 50 percent. And it stays there.

And then I think of the fact that, well, there’s going to be 32 million uninsured Americans—which doesn’t get to the underinsured Americans—who are going to be plowing money into the insurance companies, because they’re—they now have insurance coverage—they have health insurance coverage; and all kinds of things happen. And then, I think of, oh, yes, and they’re going to take those Medicaid doctors, who everybody says are going to stop serving Medicaid patients, but, lo and behold, what does the Act do? The Act brings it—for practitioners out there, it—Medicaid, and particularly in rural areas, which would be of interest to South Dakota and West Virginia, their payment levels will go up where Medicaid is now—Medicare is now. So, that may not sound sensational, but if you’re getting Medicaid reimbursement levels, that’s just about the best news you’ve ever heard.

And we’re—there’s—money’s already in there, already paid for, for building—is it 1,000 or 10,000 new healthcare centers? 1,000, OK. Nuts.

[Laughter.]

The CHAIRMAN. But, in other words, when I went to West Virginia as a VISTA volunteer, I’d—and the people I was working with lived off of a rural healthcare center, across a couple of swinging bridges in a neighboring rural county. And there they got grassroots—you know, an old Wal-Mart, except it wasn’t as big as that, but, you know, ground-floor stuff, like Vet Centers for veterans—ground floor. Not VA hospitals; they don’t like that. Go to a ground-floor thing, they’re—you get friendly folks there.

And so that all these—you know, ways to be helpful. And the fact that people who are finding healthcare difficult to navigate, even with this four-page thing that I’m overtouting—there’s going to

be—there are going to be people who help, people specifically provided for in the bill who help people work their way through getting healthcare. That can be to a company—small company, large company—that can be do an individual. They're a part of the healthcare bill.

So, I just—I would just say that, before we just obliterate an Act which has been validated by the Supreme Court and is going to stay—I always kind of prefer to get on the side of what makes things better. And, yes, when you do something as big as this, affecting 16–17 percent of the economy, there's going to be some sticker shock and some changes that have to be made, and everybody gets nervous, because it hasn't happened yet.

But, all those folks who aren't getting nervous, in the business community, about something called cybersecurity, when they get attacked—which most of them have been, actually—when they get attacked in a major way, and we shut down air traffic control systems and towers and grids and things of that sort, then people are saying, "Oh, my heavens, why didn't we pay attention to this when we had a chance to do something about it?"

Now, that sounds a little bit like a lecture, and I apologize for that. That's—is that my nature?

[Laughter.]

The CHAIRMAN. But, I really mean that. It's not just what—where we're going, it's where we are; and you have to look at both of those things. And I would just beg for that kind of—it's sort of automatic opposition. I think there's going to be a far simpler way of doing the healthcare system.

My time is way over.

Senator Thune.

Senator THUNE. Mr. Chairman, if I might—I think the one area, although you and I have different positions on the Affordable Care Act, in its passage—one thing that I think we all agree on is that more transparency is a good thing. I think the efforts that you've made to try and get more information out there is good, because it does help consumers make informed decisions.

I've always believed that the more the consumers have an opportunity to weigh what the competitive opportunities are out there, they will choose the lowest-cost option that still gives them the coverage, if it's insurance, or in the case of healthcare itself, the healthcare that they want, that delivers the quality product at the most affordable price. That's why I do think more information transparency is a good thing. And I think that having more skin in the game, so to speak, is a good thing, too, because it forces less utilization.

One of the things, I think, that really drives healthcare costs in this country is that we have an insatiable demand for healthcare. We've got some great technology out there, the best in the world. And people want to take advantage of that technology and that healthcare. But, we also have some duplication out there. A lot of things can be improved upon, in terms of delivery of healthcare. I do believe that transparency and disclosure is helpful, with regard to trying to keep prices affordable, something that most people in this country can appreciate.

Let me if I might, seek just one final comment and reaction from Mr. Trautwein—because I do think that, notwithstanding some of the elements, like the transparency provisions that you fought to get in here, and some of the things that we're addressing today, there are a lot of mandates in the bill, and a lot of requirements. I think Mr. Trautwein addressed a few of those. This is one requirement, which I think is very popular, and one which I think, in the end, will get more information out there. But, there are other mandates that I believe are also going to put upward pressure on the cost and the price of healthcare in this country. There are about 60 percent of American workers that are in self-insured plans, which are governed by ERISA.

One of the things that I'm interested in knowing is whether Title I of ERISA already are mandates of distribution of Summaries of Plan Description. How are, I would say to Mr. Trautwein, your self-insured members dealing with what could be duplicative mandates from both ERISA and the new healthcare law?

Mr. TRAUTWEIN. Thank you, Senator.

From—it's not clear to me that they're not required to produce both documents. And, in fact, all group health plans are required to produce an SBD as well as the new SBC requirement. So, that's something that stretched beyond the self-funded plans, in terms of the obligation.

Briefly addressing the Chairman's remarks, I would note that the NRF was an opponent of this law. We were for reform before passage; we continued to be for reform. Once the ink was dried on the law, we've been working with the regulators, in good faith, to try to ease compliance, make it easier for our members to comply with the law. It's a very complicated law, and some of the work with Treasury, or with HHS, in particular, in implementing it, there are going to be a lot of hoops to jump through, and employers don't like that.

But, from our perspective, we're all about compliance. We didn't sue anybody on the Affordable Care Act. We didn't submit amicus comments in the Supreme Court. We're all about compliance, right now, Mr. Chairman.

The CHAIRMAN. Well, I appreciate that.

And let me just say, in closing this—I had about 20 questions I wanted to ask, but didn't—that what you're going to see from Senator Thune and Senator Rockefeller is a fair and balanced leadership of the Commerce Committee, because we both have common values. We both come from the same kinds of States, with the same kinds of problems. But, we're different, you know, and we view the Act differently. And so be it. That's what democracy is all about.

I remain optimistic on all of this. And I think sessions like this one, where people can voice their frustrations, and where others can come back and argue, where you have people, all of whom are very knowledgeable, and the fact that—are you in the Business Roundtable? Yes. And so the—and then—you're for it; I didn't know that, and so, I apologize to you for that.

But, these are the struggles we will be going through. I mean, if we're trying to figure out how to make a—how do you get a fair explanation of a deductible that crosses all healthcare—I mean, you know, there's going to be hard stuff, and it'll take time. And

let's just try and be honest with each and do it the best that we possibly can.

In any event, you've all been terrific, and I thank you very much.
And this hearing is adjourned.

[Whereupon, at 3:58 p.m., the hearing was adjourned.]

A P P E N D I X

RESPONSE TO WRITTEN QUESTION SUBMITTED BY HON. JOHN D. ROCKEFELLER IV TO LYNN QUINCY

Question. Ms. Quincy, after the Summary of Benefits and Coverage (SBC) became law in March 2010, AHIP (American's Health Insurance Plans) and then later AHIP together with the Blue Cross Blue Shield Association (BCBSA) paid for two separate consumer focus group studies to test early versions of the SBC forms. We have attached these studies for your review. The first round of consumer testing AHIP did focused on how consumers interacted with the SBC forms. AHIP's testing found that the SBC was "valued by consumers," and that:

The idea that there might be a standard form or common template that health insurance companies would use to summarize costs and benefits was universally hailed as a great move. All participants felt that they personally would benefit by having a quick read of any given plan and being better able to compare plans. A common template would provide consistency and uniformity.

In their second round of testing AHIP and BCBSA focused on how consumers interacted with the SBC's Coverage Examples. The researchers found that:

[A] majority of participants felt the inclusion of examples was helpful in that it gave them a different way to view, compare, and understand the cost implications of various plans.

Ms. Quincy, your organization, Consumers Union, also conducted focus group with consumers. Were the findings of your research consistent with the findings of AHIP and the BCBSA?

Answer. Thank you for this question. I think it is remarkable how similar the findings were between the AHIP/BCBSA studies and the Consumers Union studies. This commonality underscores the robustness of the findings. All reports are public documents. In the case of Consumers Union's testing, outside observers were invited to view the consumer testing, lending further transparency to the process and findings.

Our written testimony and the study reports provide a strong written record of these findings. I will not reiterate the major findings here except to state that they comport with and even build upon the AHIP and BCBSA findings. Policymakers can act upon this information, increasing and extending consumer access to timely and accurately completed SBCs, with complete confidence that these new documents help consumers.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. AMY KLOBUCHAR TO LYNN QUINCY

Question 1. I really believe in paying for quality. During the hearing in 2009, I asked how to incorporate quality measures into transparency materials and the response I got was that's 300 level learning, we're still at insurance 101. Was there any discussion during the development process to incorporate various quality measures?

Answer. I don't believe so. The NAIC felt it was all they could do to use their multi-stakeholder process to meet the statutory requirements for the SBC. These requirements don't include quality measures, although the Affordable Care Act (ACA) clearly places great importance on quality measures in other sections. For example, core functions an Exchange must provide include assignment of a price and quality rating to plans and the presentation of enrollee satisfaction survey results.

Question 2. With the lessons learned from the NAIC process, the feedback from focus groups and the industry, are there steps we can take to also start providing consumers with information on quality?

Answer. Absolutely! The new quality reporting requirements in the ACA, and heightened consumer awareness of new health plan options and ways to buy coverage, are a golden opportunity to put better measures in front of consumers. However, current research suggests that more consumer testing of quality measures may be needed to ensure wide-spread and appropriate use of the measures.

While quality was not the focus of our own testing, we did solicit consumers' views on quality directly and indirectly. Many consumers associate health plan quality with (a) comprehensive coverage and/or (b) high quality providers in the network. This doesn't mean we can't be successful build plan and provider quality measures in other domains, but it does caution us that such measures must be carefully tested and artfully named so that their use is intuitive and appropriate.

We highly recommend a robust course of consumer testing to see which quality measures, broadly defined, will most benefit consumers. The broad range of measures to be tested should include a rigorous, standard way to measure provider network adequacy and a summary measure indicating how providers perform with respect to patient safety, as well as the conventional measures used today.

Research has shown that the performance of individual physicians and hospital service lines is strongly preferred by consumers over performance information aggregated at physician group or hospital wide levels. Work should be done to overcome current barriers to the provision of this information.

Getting quality information into the hands of consumers is critically important but much remains to be done to identify the best consumer facing measures and make these accessible, understandable, and relevant.

Question 3. Do you think that this would be a useful addition to the summary of benefits and coverage documents?

Answer. We recommend using consumer testing to rigorously answer this question. While we are confident that well tested quality measures will help consumers, the question of which ones and how to include would need to be answered. For example, it is possible that only one or two summary measures are appropriate to use in the SBC, with additional detail available on health plan comparison websites.

Question 4. Are there other ways you think these documents can be strengthened?

Answer. Yes! I strongly recommend the following

- Getting the SBC form "designed" by a graphic designer versed in these types of communications. My written testimony includes an example of how design changes could improve the form. Consumer testing should be used to ensure that the revisions enhance the experience for the consumer, without reducing the value of the current version.
- Bringing back a row for premium information on the first page, as was included in the original NAIC recommendations. These recommendations provided a robust mechanism for the provision of premium information on the SBC, and reflect input from a wide variety of stakeholders.
- Including more coverage examples as soon as possible, and experimenting with moving this information forward in the document.
- Abandon the use of national Medicare prices as the basis for the coverage example calculations and instead substituting realistic private sector prices; trended to accurate represent costs for the year that coverage will be effective.

My written testimony contains further suggestions.

RESPONSE TO WRITTEN QUESTION SUBMITTED BY HON. AMY KLOBUCHAR TO
MARGARET E. O'KANE

Question. I really believe in paying for quality. During the hearing in 2009, I asked how to incorporate quality measures into transparency materials and the response I got was that's 300 level learning, we're still at insurance 101.

- Was there any discussion during the development process to incorporate various quality measures?
- With the lessons learned from the NAIC process, the feedback from focus groups and the industry, are there steps we can take to also start providing consumers with information on quality?
- Do you think that this would be a useful addition to the summary of benefits and coverage documents?
- Are there other ways you think these documents can be strengthened?

Answer. I also believe strongly in paying for quality and making quality information transparent and easy for consumers to use. Focus groups that we conducted with the California Healthcare Foundation found that with help, consumers quickly understand that quality does not necessarily cost more—and that it can cost less. Consumers generally do need help to understand this, as it is not intuitive for most people. However, once consumers do understand it, they want to use cost and quality information together to help them select a high quality, low-cost health plan or physician organization. We also found that the people most interested in this information are the uninsured who will be accessing health care coverage through State Health Insurance Exchanges.

Our report on these focus group findings, *Value Judgment: Helping Health care Consumers Use Quality and Cost Information*,¹ includes important lessons on how to make this information meaningful to consumers and move beyond the “insurance 101” stage.

For example, most people prefer simpler formats that use a symbol to indicate overall value, and they want to know the source of the data in order to assess its credibility.

It is not clear whether the standardized Summary of Benefits and Coverage would be a good place to provide consumers with quality information. Specific testing would be needed to determine if consumers wanted quality information there and, if so, how to make it useful to them.

State Health Insurance Exchange web portals, however, are an ideal place to give consumers information on quality, along with total cost of care. Minnesota’s Exchange already has a specific work group focusing on this important opportunity. It takes time to measure and report on the actual quality of care that plans provide, so Exchange plans’ quality information at first will be limited to accreditation status and patient experience ratings for similar plans offered by the same sponsors. Once we can collect and report on performance measures for care provided in Exchange plans, we will be able to give consumers robust information on the actual quality of care, patient experience, and total costs of care in each Exchange plan. This will greatly increase consumers’ ability identify and enroll in plans that provide the best value for their health care dollars.

To make the most of this opportunity, there are important principles Exchanges should follow to help consumers make the most of transparent cost and quality information. Exchanges need to:

- Apply lessons from the science of behavioral economics and “choice architecture” to help guide consumers to plans offering the best value.
- Present information to consumers as simply as possible. Studies and experience shows that too much information can bog down the enrollment process or prevent someone from choosing a plan.
- Build from existing measures and collection systems to ensure straightforward, efficient implementation.
- Limit collection to data that has a clear use; there is considerable cost for reporting unused data.
- Add more information, new measures and quality improvement and assurance strategies over time. Give stakeholders the opportunity to comment on direction, and give plans and states the opportunity to implement system changes.



¹ <http://www.ncqa.org/Portals/0/Public%20Policy/CHCF%20ValueJudgmentQualityCostInformation.pdf>